# HELP EFFICIENT, ACCESSIBLE, LOW-COST, TIMELY HEALTHCARE (HEALTH) ACT OF 2003

## HEARING

BEFORE THE

## COMMITTEE ON THE JUDICIARY
## HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

ON

**H.R. 5**

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# CONTENTS

MARCH 4, 2003

OPENING STATEMENT



WITNESSES



APPENDIX

STATEMENTS SUBMITTED FOR THE HEARING RECORD



MATERIAL SUBMITTED FOR THE HEARING RECORD

# HELP EFFICIENT, ACCESSIBLE, LOW-COST, TIMELY HEALTHCARE (HEALTH) ACT OF 2003

**TUESDAY, MARCH 4, 2003**

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE JUDICIARY,
*Washington, DC.*

The Committee met, pursuant to call, at 9:20 a.m., in Room 2141, Rayburn House Office Building, Hon. Lamar S. Smith presiding.

Mr. SMITH. [Presiding.] The Judiciary Committee will come to order. Today's hearing is on H.R. 5, the "Help Efficient, Accessible, Low-Cost, Timely Healthcare Act of 2003", otherwise known as the HEALTH Act.

We will start with opening statements by me and by the Ranking Member, Mr. Conyers, and without objection, the opening statements of all other Members will be made part of the record.

Mr. SMITH. After the opening statements, we will look forward to hearing from our witnesses.

I will recognize myself first for an opening statement.

Today America faces a national insurance crisis that is destroying our health care system. Medical liability insurance rates have soared, causing major insurers either to drop their coverage or raise premiums to unaffordable levels.

Doctors and other health care providers have been forced to abandon patients and practices, particularly in high-risk specialties such as emergency medicine, brain surgery, obstetrics and gynecology.

Women are particularly hard hit, as are low-income individuals and rural residents. This is an intolerable problem that cries out for action.

H.R. 5, the HEALTH Act, is modeled after California's quarter-century-old and highly successful health care litigation reforms. Like California's Medical Injury Compensation Reform Act, known as MICRA, the HEALTH Act includes a $250,000 cap on non-economic damages, limits on the contingency fees lawyers can charge, and authorization for defendants to introduce evidence to prevent double recoveries.

As a result of MICRA, since 1975 premiums paid in California increased only 167 percent, while premiums paid in the rest of the country increased 505 percent, or three times as much. What works in California might work across America.

The Congressional Budget Office has found that, "In States that currently do not have controls on malpractice torts, the HEALTH

Act would significantly lower premiums for medical malpractice insurance from what they would otherwise be under current law."

If California's legal reforms were implemented nationwide, we could spend billions of dollars more annually on patient care.

Nothing in the HEALTH Act limits in any way the award of economic damages. Economic damages include anything of value that can be quantified, including lost wages, lost services, medical costs, and the cost of pain-reducing drugs and lifetime rehabilitation care. Reasonable legal reforms, such as those in the HEALTH Act, still allow for very large multimillion-dollar awards to deserving victims. In just the last year, for example, an injured child in California received an award of $84 million, and a 30-year-old homemaker received an award of $12 million for economic damages.

According to the Department of Health and Human Services, "Unless a State has adopted limitations on noneconomic damages, the cost of these awards is paid by all other Americans through higher health care costs, higher health insurance premiums, higher taxes, reduced access to quality care, and threats to quality of care."

The American people understand this problem. A poll conducted in early February shows that 59 percent of Americans believe the crisis should be solved, either by reining in personal injury lawyers or by placing caps on the amounts juries can award. The obvious cause of skyrocketing medical liability premiums is escalating jury verdicts. The median malpractice jury award doubled between 1995 and 2000 from a half a million to $1 million, and that doesn't reflect the huge cost of cases that don't result in jury awards. In fact, 70 percent of all medical malpractice claims result in no payments, because claims are either dismissed or withdrawn.

The CEO of Methodist Children's Hospital in San Antonio, and also one of the only three pediatric neurosurgeons in the area, someone I met with just a few weeks ago, has seen his premiums increase from less than $20,000 to $85,000 over the last 10 years. He has been sued three times. In one case his only interaction with the person suing was that he stepped into her child's hospital room and asked how the child was doing. Each jury cleared him of any wrongdoing, and the total amount of time all three juries spent deliberating was less than 1 hour. Of course, the doctor's insurance company did spend a great deal of time, money and effort on his defense.

Another doctor from Texas, a family physician, was sued 12 times in 13 years. All of the suits were dropped, but her insurance went up nearly 200 percent.

An out-of control health care litigation system also costs taxpayers billions of dollars annually. As former Democratic Senator George McGovern has written, "The legal fear drives doctors to prescribe medicines and order tests, even invasive procedures, that they feel are unnecessary. Reputable studies estimate that this defensive medicine squanders $50 billion a year, enough to provide medical care to millions of uninsured Americans."

As Representatives of the American people, Congress has a choice. Will we help solve the current health care crisis by passing the HEALTH Act?

Now, that concludes my opening statement, and now I will recognize the gentleman from Michigan, Mr. Conyers, for his opening statement.

Mr. CONYERS. Thank you, Mr. Chairman. Good morning, Members and friends. I am happy to be here. We are confronted with a very important problem, and like many legislative problems, it depends on what perspective you are looking at; it depends on what experience you bring to the subject.

So I would like to begin with an economic consideration. The reason malpractice insurance premiums are rising, the basic reason, is that investment income by insurance companies is plummeting. As we all know, insurers make their money, really, mostly from investment income. During years of high stock market returns and interest rates, malpractice premiums go down. When investment income decreases, and we are in the middle of a 4-year bear market, the industry responds by sharply increasing premiums and reducing coverage, creating a liability insurance crisis. This boom-bust cycle took place in the 1970's and 1980's, and it is happening again now.

Another reason is that draconian laws capping damages do not reduce insurance premiums. A comparison of States that have enacted severe tort restrictions and those that have not, which was performed by the Center for Justice and Democracy, found no correlation between tort reform and insurance rates. Indeed, some of the resisting States experienced lower increases in insurance rates, while some States that enacted tort reforms experienced higher rate increases relative to the national trends.

For example, last year's data showed that in the practice of internal medicine, States with caps on damages had higher premiums than States without caps. For general surgeons, insurance premiums were 2.3 percent higher in States with caps on damages. On average, malpractice premiums were no higher in the 27 States that have no limitation on malpractice damages than in the 23 States that do have such limits.

Now, Mrs. Sherry Keller is here, so I am not going to tell you about her situation, but with this bill the big insurance companies are trying to convince us that the cause of skyrocketing medical malpractice premiums is trial lawyers. And they have really been bashed these last few years, haven't they?

My colleagues, the reality is grossly negligent health care professionals unfortunately have more to do with the high awards than the lawyers. The reality is approximately 100,000 people die each and every year from medical malpractice. Whatever the reasons for the anger the President has toward lawyers, and he is one, his proposal doesn't hurt lawyers nearly as much as it hurts innocent victims of medical malpractice. We will all be watching very carefully and listening to his remarks before the American Medical Association, which will come on shortly.

I thank you for this opportunity, Mr. Chairman.

Mr. SMITH. Thank you, Mr. Conyers.

I would like to thank all Members for their attendance today. This is an important subject, and we appreciate their interest and their presence, and also the interest shown by those who are in the audience today as well.

Let's proceed to our witnesses, and our first witness is Sherry Keller. Mrs. Keller is here today to tell us how her experience with medical care left her severely injured.

Our next witness is Leanne Dyess, from Vicksburg, Mississippi. She is here to testify about how this patient access crisis has affected the lives of herself and her family. Her husband Tony suffered from permanent brain injury because neurosurgeons near the site of the car accident had been priced out of the profession by unaffordable medical malpractice liability insurance rates.

Our third witness is Donald J. Palmisano, who is a doctor and a lawyer, as well as the president-elect of the American Medical Association, which represents the Nation's physicians. Dr. Palmisano is a general and vascular surgeon from New Orleans, Louisiana, where he was selected recently as one of the top doctors in New Orleans. Dr. Palmisano is also on the board of directors of the National Patient Safety Foundation.

Our final witness is Lawrence E. Smarr, President of the Physician Insurers Association of America. The Physician Insurers Association of America is a trade association of more than 60 medical professional liability companies owned and operated by doctors and dentists. Collectively these companies insure 60 percent of America's private practice physicians as well as dentists, hospitals and other health care providers.

I thank you all for being with us here this morning. I need to alert you to the fact that testimony will be limited to 5 minutes or less, if you want to summarize it, and we appreciate your participating today. As I mentioned a while ago, your complete statements will be made part of the record.

Speaking of that, let me take care of one matter here. Without objection, I would also like to be made a part of the record a new Health and Human Services report on medical liability that was released yesterday, and two articles in *The Washington Times* from yesterday on the President's speech at the University of Scranton, in Pennsylvania on January 16th in regard to medical malpractice reforms, and also 10 questions and answers regarding the HEALTH Act. And without objection, so ordered.

[The information referred to follows in the Appendix]

Mr. SMITH. The gentleman from Massachusetts.

Mr. DELAHUNT. Thank you, Mr. Chairman. And before we begin, I would also like to submit for the record a statement by Mr. John McCormack of Pembroke, MA, who is a constituent of mine. In there he explains what happened to his daughter as a result of medical errors that had severe and profound consequences, not just resulting in her death, but for the entire family.

Mr. SMITH. Without objection, that will be made a part of the record as well, Mr. Delahunt. Thank you.

[The information referred to follows in the Appendix]

Mr. SMITH. Let's begin. Mrs. Keller, if you will start, please.

## STATEMENT OF SHERRY KELLER, CONYERS, GA

Mrs. KELLER. Good day, ladies and gentlemen. I thank you for the opportunity to speak to you today. My name is Sherry Keller. I am a victim of medical malpractice, and I beg for your consideration of my story and the McConnell amendment.

I come here at risk of my own best interests, but my commitment to this cause commands my heart to do so without any reservation. This is the issue, not the money. One week after a complete hysterectomy, the staples were removed from my incision site. That night the wound oozed, and upon notification to my doctor, she told me to come into the office so she could clean the wound.

I was placed up on the gyno bed. She began to clean the wound, and when she did so, she pulled on it. And when she pulled on it, I opened up like a Ziplock bag, hip to hip. While I was now going to take a little bit more time than what she had planned, she left me there like that, in the interim, to see other patients, make a few phone calls. I had gone into shock, lost consciousness, and fell from the bed, hitting my head on the way down, C2 through C7 spinal cord injury, quite similar to that of actor Christopher Reeve or that killed Dale Earnhardt.

I lost and regained consciousness at least five times on the floor of the doctor's office, in an effort to try to get out into the hallway, in order to be found. Making it out to the hallway, I called, "Help me." the doctor and the nurses then scrambled, saw me laying there like that, naked from the waist down, my intestines hanging out, in severe shock. They picked me up from the hallway, and that is when I began screaming in pain and lost the use of my arms.

My husband was called back from the waiting room; an argument between the two of them about whether or not I needed an ambulance. She wanted him to take me to the ER on his own, and he insisted that he could not handle me in that condition. An ambulance was called, but I was not even afforded a neck collar due to the doctor's orders of transport only.

Patient care meant nothing. Doctor's power meant everything. Unbeknownst to me, she had called ahead to the ER and let them know that I was her patient, and she would take care of it.

I was left in the ER for 2½ hours before she was able to get to the ER to dress my wound, my complaints of pain, the obvious contusion to my head ignored, arm function limited by that point, unable to stand completely on my own. I was just sore from the fall. Go home. I was sent home with a broken neck because of doctor power and doctor protocol. Patient care meant nothing.

This is not to impugn all doctors. This is not to say all doctors are bad. I do not hold resentment toward all doctors. My neurosurgeon was a miracle worker. He saved me. But just as there are good and bad lawyers, good and bad policemen, there are good and bad doctors.

Our bad doctors need to be held accountable. Just as President Bush has called for the executives of Enron to be held accountable, doctors need to be held accountable, and the only recourse I as a citizen have is our jury system. That is my right. That is the only right and the only venue I have to hold the physician accountable for the care and trust that we are conditioned to give them. Even in a doctor office visit they hold our lives in their hands, and far too often with far too cavalier an attitude.

I had chosen to give up any form of a career in order to raise my children, both college scholarship award winners, both academically excelling very well, my younger is now straight A's, both contributing to this society. But because of my choice to bring in re-

sponsible members to society, my value through this, through the McConnell bill, will be nothing. Because I had no economic input, my value as a person is nothing. The only award, the only recourse, the only accountability I will have is through the pain and suffering.

I have heard several Representatives mention a malpractice lawsuit is like winning the lottery. Well, I would like to ask any of you who would turn over a limb or a lung or a life for a lottery ticket. It is not a lottery. I am not in the position to win anything. I would gladly give back Bill Gates' money if I could trade it back for my spinal cord. No amount of compensation is going to pay me back for what I have lost, the ability for me to reach for this paper takes extraordinary effort; the ability to just go to the bathroom, gone. Things that we take—everyday movement, taken from me. I will never have the freedom a healthy body has; never the complete use of my arms, legs. I suffer every day, 24 hours a day. Every time I have to try to reach for something, the pain is excruciating. No amount of medicine can take the pain away. It can subside, but it is always there. In my dreams I suffer. I am awakened many times during the night because of problems in my spinal cord. I can't even sleep through the night.

What kind of money is going to compensate that? None. But to say that $250,000 is more than enough is an insult. I now have to hire cleaning people, a driver to do basic errands, go to the bank. A 10-minute trip to the grocery store now takes 3 hours, of which I have to hire somebody to do. I will have to do so forever. These are out-of-pocket expenses that would not be covered. All of the chores, the errands, gardening, landscaping, cleaning, you name it, and for the rest of my life I now have to hire somebody else to do it, and not only is it degrading, but it is coming out of my pocket.

Mr. SMITH. Mrs. Keller, thank you for your testimony.

[The prepared statement of Mrs. Keller follows:]

PREPARED STATEMENT OF SHERRY KELLER

First, I want to thank Chairman Sensenbrenner and Congressman Conyers. I greatly appreciate the opportunity you have given me. My name is Sherry Keller and I am a victim of medical malpractice.

I am 44 years old. I live with my husband in Conyers, Georgia, a suburb of Atlanta, and have two college-age sons. This is my story.

About 4 years ago, I underwent a complete hysterectomy. The doctor failed to suture and staple the incision site, instead only stapling me shut. One week after the staples were removed, I noticed that one area of the wound was oozing. After reporting this to my doctor, I was called into her office the next day so she could clean the wound.

Once there, she had me lie on the examination table. She pulled on the incision, and I opened up like a zip-lock bag, just as though I were in surgery. The doctor said she was going to call a wound care specialist and then left me alone for 35–45 minutes while she saw other patients and made personal calls to her home.

I went into shock, lost consciousness and fell from the table, hitting my head on the counter on the way down, causing c2-c7 spinal cord injury similar to that sustained by actor Christopher Reeve and deceased race car legend Dale Earnhardt. I also suffered traumatic brain injury and a severe concussion.

Eventually, after going in and out of consciousness at least 5 times, drenched in sweat and with my guts hanging out, I was able to pull myself out into the hallway to get help. I was immediately picked up out of the hallway so that other patients wouldn't see me, causing me to lose all function in my arms.

The doctor then began arguing with my husband about why he, not an ambulance, should take me to an emergency room. My husband finally prevailed, and the doctor called for an ambulance. When the ambulance came, I was not given a neck

collar, because, as I later found out, the doctor had requested transport only and the EMS workers were required to follow her orders.

After arriving at the emergency room, I was basically given no medical attention, because my doctor had instructed the ER that she would take care of me when she arrived at the hospital. Two and a half hours later, the doctor arrived, cleaned my wound and sent me home, explaining that any pain and soreness I was experiencing were caused by the fall. I was never given steroids, which could have reduced some of the swelling and prevented the damage from progressing. Once home, I kept falling down and could barely walk.

Now, four years later, I am an incomplete quadriplegic. I will never have the freedom a healthy body has, never be able to use my arms for the simplest of tasks, never walk holding a child's hand, never explore and see the splendour of this country. Even a simple trip to the bathroom is now gone. Every day, each and every day, for the rest of my life.

We, as victims, endure pain and suffering 24 hours a day, with physical pain that no amount of medicine can take away. Suffering comes even in sleep, in dreams and in one's physical state every day and every night. It will be so for the rest of my life, all at the hands of one negligent physician, whom we as a society are conditioned to trust.

Far too cavalier an attitude within the medical ranks regarding public trust results in untold pain and suffering within the general public, to be lived constantly for our entire lives. The inability to reach, sit, anything and everything the average person takes for granted, also produces incalculable suffering. If pain and suffering cannot be measured, how can it possibly be capped?

I gave my life to raising my 2 sons and taking care of my family. I feel I've contributed more to society by the choice I made. But under H.R. 5, my value is nothing. Despite the extent of my physical pain and suffering, which forced me to abandon my hopes of becoming a painter, the only compensation I would receive is $250,000. So when I hear doctors and legislators say that medical malpractice awards are like winning the lawsuit lottery, it really burns my butt.

It is an outrage that victims of medical malpractice are to be trivialized for the profit margin of big business. In the shadow of Enron, where President Bush called for the accountability of all responsible, how can physicians not be held accountable for the extent to which their errors have devastated lives?

Limiting compensation to victims while still fully protecting doctors is not only terribly unfair, it is immoral, outrageous and reeks of injustice. We are the innocent victims. To punish us a second time literally adds insult to injury.

Doctors are meticulously trained to cure us, keep us alive and improve our quality of life. They take a solemn oath to "do no harm." It is a noble profession, a calling of sorts. We put our trust in doctors unlike any other profession. They are human. Mistakes are made, sometimes honest mistakes and sometimes blatantly incompetent ones. Mistakes cost lives, create medical nightmares and destroy the lives of victims and their families.

The goal must be to reduce medical negligence. This can only happen if physicians are held accountable. Laws and proposals that increase the obstacles sick and injured patients face in the already difficult process of prevailing in court are the wrong way to respond to any medical malpractice insurance "crisis." Tort restrictions only reduce the financial incentive of institutions like hospitals and HMOs to operate safely, when our objectives should be deterring unsafe and substandard medical practices while safeguarding patients' rights.

Caps cannot be allowed, not in a great society like ours that bases itself on fairness and equality to all.

Thank you for your time and consideration.

Mr. SMITH. Mrs. Dyess.

## STATEMENT OF LEANNE DYESS, MEMBER, COALITION FOR AFFORDABLE AND RELIABLE HEALTH CARE

Ms. DYESS. Chairman Smith, Ranking Member Conyers, distinguished Members of the House Judiciary Committee, it is an honor for me to sit here before you this morning to open up my life and the life of my family in an attempt to demonstrate how medical liability costs are hurting people across America.

While others may talk in terms of economics and policy today, I want to speak to you from the heart. I want to share with you the

life my two children and I are now forced to live because of a crisis in health care that I believe can be fixed. And when I leave and the lights are turned off and the television cameras go away, I want you and all America to know one thing, and that is this crisis isn't about insurance. It is not about doctors or even hospitals or personal injury lawyers. It is a crisis about individuals and their access to what I believe is otherwise the greatest health care in the world.

Our story began on July 5 of last year when my husband Tony was returning from work in Gulfport, MI. We had started a new business. Tony was working hard, as I was. We were doing our best to build a life for our children, and their futures were filled with promise. Everything looked bright.

Then in an instant everything changed. Tony was involved in a single-car accident. They suspect he may have fallen asleep, though we will never know. What we do know is that after removing him from the car, they rushed Tony to Garden Park Hospital in Gulfport. He had injuries and required immediate attention.

Shortly thereafter, I received a phone call I pray no other wife will ever have to receive. I was informed of the accident and told the injuries were serious, but I cannot describe to you the panic that gave way to hopelessness when they told me, we don't have the specialists necessary to take care of him. We will have to airlift him to another hospital.

I couldn't understand this. Gulfport is one of the fastest growing and most prosperous regions in Mississippi. Garden Park is a good hospital. Where were the specialists who could have taken care of my husband?

Almost 6 hours passed before Tony was airlifted to University Medical Center, 6 hours for the damage to his brain to continue before they had a specialist capable of putting a shunt into the back of his head to relieve the pressure on the brain, 6 unforgettable hours that changed our life.

Today Tony is permanently brain-damaged. He is mentally incompetent, unable to care for himself, unable to provide for his children, unable to live the vibrant, active and loving life he was living just moments before the accident.

I could share with you the panic of a women suddenly forced into the role of both mother and father to her teenaged children, of a women whose life is suddenly caught in limbo, unable to move forward or backwards. I could tell you about a woman who now had to worry about the constant care of her husband, who had to make concessions she never thought she would have to make in order to be able to pay for his care and therapy.

But to describe this would be to take us away from the most important point and value of what I have learned. Mr. Chairman, I have learned that there was no specialist on staff that night in Gulfport because rising medical liability costs had forced physicians in that community to abandon their practices. In that area, in that time, there was only one doctor who had the expertise to take care of Tony, and he was forced to cover multiple hospitals, stretching him thin and unable to care for everyone. Another doctor quit his practice just days before Tony was admitted because his insurance company terminated all of the medical liability policies nationwide.

That doctor could not obtain affordable coverage. He couldn't practice. And on that hot night in July, my husband and our family drew the short straw.

I have also learned that Mississippi is not unique, that this crisis rages in States all across America. It rages in Nevada where young expectant mothers cannot find OB-GYNs. It rages in Florida where children cannot find pediatric neurosurgeons. It rages in Pennsylvania, where the elderly who have come to depend on their orthopedic surgeons are being told that those trusted doctors are moving to States where practicing medicine is affordable and less risky.

The real danger of this crisis is that it is not readily seen. It is like termites in the structure of a home. They get into the woodwork, but you cannot see the damage. The walls of the house remain beautiful, but you don't know what is going on beneath the surface, at least not for a season. Then one day you go to hang a picture or a shelf, and the whole wall comes down. Everything is destroyed.

Before July 5, I was like most Americans, completely unaware that just below the surface of our Nation's health care delivery system serious damage was being done by excessive and frivolous litigation.

Mr. SMITH. Could I ask you to summarize the rest of your testimony?

Ms. DYESS. In all of these cases, all across America, if you go somewhere, to an emergency room, you expect there to be a doctor there, all of us. We have to do whatever it takes, whatever it takes, to get your child some care, your parents, your grandparents, ourselves care when we need it. If we don't do something, down the road she might not have a doctor to take care of her, one that really does her the—like the neurosurgeon she was talking about. We might not have anybody to take care of us, any of us. We don't need to stand still.

Mr. SMITH. Thank you, Mrs. Dyess.

[The prepared statement of Mrs. Dyess follows:]

PREPARED STATEMENT OF LEANNE DYESS

Chairman Sensenbrenner, Ranking Member Conyers, distinguished members of the House Judiciary Committee:

It's an honor for me to sit before you this afternoon—to open up my life, and the life of my family, in an attempt to demonstrate how medical liability costs are hurting people all across America. While others may talk in terms of economics and policy today, I want to speak from the heart.

I want to share with you the life my two children and I are now forced to live because of a crisis in health care that I believe can be fixed. And when I leave and the lights turn off and the television cameras go away, I want you—and all America—to know one thing, and that is that this crisis is not about insurance. It's not about doctors, or hospitals, or even personal injury lawyers. It's a crisis about individuals and their access to what I believe is, otherwise, the greatest health care in the world.

Our story began on July 5th of last year, when my husband Tony was returning from work in Gulfport, Mississippi. We had started a new business. Tony was working hard, as was I. We were doing our best to build a life for our children, and their futures were filled with promise. Everything looked bright. Then, in an instant, it changed. Tony was involved in a single car accident. They suspect he may have fallen asleep, though we'll never know.

What we do know is that after removing him from the car, they rushed Tony to Garden Park hospital in Gulfport. He had head injuries and required immediate attention. Shortly thereafter, I received the telephone call that I pray no other wife will ever have to receive. I was informed of the accident and told that the injuries

were serious. But I cannot describe to you the panic that gave way to hopelessness when they somberly said, "We don't have the specialist necessary to take care of him. We need to airlift him to another hospital."

I couldn't understand this. Gulfport is one of the fastest growing and most prosperous regions of Mississippi. Garden Park is a good hospital. Where, I wondered, was the specialist—the specialist who could have taken care of my husband?

Almost six hours passed before Tony was airlifted to the University Medical Center—six hours for the damage to his brain to continue before they had a specialist capable of putting a drain into his head to relieve the pressure on his brain—six unforgettable hours that changed our life.

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I could share with you the panic of a woman suddenly forced into the role of both mother and father to her teenage children—of a woman whose life is suddenly caught in limbo, unable to move forward or backward. I could tell you about a woman who now had to worry about the constant care of her husband, who had to make concessions she thought she'd never have to make to be able to pay for his therapy and care. But to describe this would be to take us away from the most important point and the value of what I learned.

Chairman Sensenbrenner, I learned that there was no specialist on staff that night in Gulfport because rising medical liability costs had forced physicians in that community to abandon their practices. In that area, at that time, there was only one doctor who had the expertise to care for Tony and he was forced to cover multiple hospitals—stretched thin and unable to care for everyone. Another doctor had recently quit his practice just days before Tony was admitted because his insurance company terminated all of the medical liability policies nationwide. That doctor could not obtain affordable coverage. He could not practice. And on that hot night in July, my husband and our family drew the short straw.

I have also learned that Mississippi is not unique, that this crisis rages in states all across America. It rages in Nevada, where young expectant mothers cannot find ob/gyns. It rages in Florida, where children cannot find pediatric neurosurgeons. And it rages in Pennsylvania, where the elderly who have come to depend on their orthopedic surgeons are being told that those trusted doctors are moving to states where practicing medicine is affordable and less risky.

The real danger of this crisis is that it is not readily seen. It's insidious, like termites in the structure of a home. They get into the woodwork, but you cannot see the damage. The walls of the house remain beautiful. You don't know what's going on just beneath the surface. At least not for a season. Then, one day you go to hang a picture or shelf and the whole wall comes down; everything is destroyed. Before July 5th, I was like most Americans, completely unaware that just below the surface of our nation's health care delivery system, serious damage was being done by excessive and frivolous litigation—litigation that was forcing liability costs beyond the ability of doctors to pay. I had heard about some of the frivolous cases and, of course, the awards that climbed into the hundreds of millions of dollars. And like most Americans I shook my head and said, "Someone hit the lottery."

But I never asked, "At what cost?" I never asked, "Who has to pay for those incredible awards?" It is a tragedy when a medical mistake results in serious injury. But when that injury—often an accident or oversight by an otherwise skilled physician—is compounded by a lottery-like award, and that award along with others make it too expensive to practice medicine, there is a cost. And believe me, it's a terrible cost to pay.

Like most Americans, I did not know the cost. I did not know the damage. You see, Mr. Chairman, it's not until *your* spouse needs a specialist, or you're the expectant mother who needs an ob/gyn, or it's *your* child who needs a pediatric neurosurgeon, that you realize the damage beneath the surface.

From my perspective, sitting here today, this problem far exceeds any other challenge facing America's health care—even the challenge of the uninsured. My family had insurance when Tony was injured. We had good insurance. What we didn't have was a doctor. And now, no amount of money can relieve our pain and suffering. But knowing that others may not have to go through what we've gone through could go a long way toward helping us heal.

Congressman Sensenbrenner, I know of your efforts to see America through this crisis. I know this is important to you, and that it's important to the President. I know of the priority Congress is placing upon doing something... and doing it now. Today, I pledge to you my complete support. It is my prayer that no woman—or anyone else—anywhere will ever have to go through what I've gone through, and

what I continue to go through every day with my two beautiful children and a husband I dearly love.

Mr. SMITH. Dr. Palmisano.

**STATEMENT OF DONALD J. PALMISANO, M.D., PRESIDENT-ELECT, AMERICAN MEDICAL ASSOCIATION**

Dr. PALMISANO. Thank you, Mr. Chairman. Good morning. I am Donald Palmisano, president-elect of the American Medical Association, and a surgeon from New Orleans.

The policy of the American Medical Association is decided through a democratic policymaking process involving physician delegates representing every State, nearly 100 national specialty societies, Federal service agencies and other group sections. AMA policy dictates support for national medical liability reform. My testimony represents this policy.

So again, Mr. Chairman, thank you for inviting the AMA to participate in today's hearing. I want to express our gratitude to you and the other cosponsors of H.R. 5 for your efforts to bring reasonable reforms to our broken medical liability system.

Mr. Chairman, you know that our health care system is facing a crisis when patients have to leave their State to receive urgent surgical care, or when a pregnant woman cannot find an OB-GYN physician to monitor her pregnancy and deliver her baby, or when community health centers have to reduce their services or close their doors because of liability insurance concerns.

You know that our health care system is facing a crisis when efforts to improve patient safety and quality are stifled because of lawsuit fears. Escalating jury awards and the high costs of defending against lawsuits, even meritless suits, are causing medical liability insurance premiums to soar. Several recent Government and private sector reports referenced in our written testimony confirm this. Over the past 2 years, many physicians have been hit with medical liability premium increases of 25 percent to 400 percent, and reports show that the average jury award is reaching $3.5 million.

The medical liability crisis is a growing national problem that affects more than just physicians and other health care professionals and institutions. The medical liability crisis has become a serious problem for patients, affecting their ability to access health care services that would otherwise be available to them, including services provided to Medicare and Medicaid patients. As medical liability insurance becomes unaffordable or unavailable, physicians are being forced to close their practices or drop vital services, seriously affecting patient access to care.

There are now 18 States that are in crisis, up from 12 States last year, and in many other States a crisis is looming. A key provision of H.R. 5 is a $250,000 limit on noneconomic damages.

There is a direct and compelling Federal interest in reforming our outmoded medical liability system. According to estimates by HHS, excessive medical liability adds $47 billion annually to what the Federal Government pays for Medicare, Medicaid and other Government programs. We need a national solution. And I mention—that is why the AMA is supporting H.R. 5, and that is why we join with numerous other members of a broad-based coalition

known as the Health Coalition on Liability and Access to urge this Congress to promptly reform the medical liability system.

A key provision is the $250,000 noneconomic cap, and there is flexibility in the bill for States to adjust the cap to suit their particular circumstances. In Florida, a nonpartisan task force recently found that the greatest long-term impact on health care provider liability insurance rates is a $250,000 cap on noneconomic damages, which would eliminate crisis of availability and affordability of health care in Florida.

As discussed in our written statement, this limit on noneconomic damages has worked in California, and it can work nationwide.

Mr. Chairman, as you have recognized, the time for action is past due. We must act now to fix our broken medical liability system. Recent polls show that the American public is in favor of reasonable limits on noneconomic damages. We must bring common sense back to our courtrooms so patients can have access to their physicians, whether in emergency rooms, delivery rooms or operating rooms. Thank you very much.

Mr. SMITH. Thank you, Dr. Palmisano.

[The prepared statement of Dr. Palmisano follows:]

PREPARED STATEMENT OF DONALD J. PALMISANO, MD, JD

On behalf of the physician members of the American Medical Association (AMA), I appreciate the opportunity to testify before you today regarding an issue that is seriously threatening the availability of and access to quality health care for patients. I would especially like to express our gratitude to you, Mr. Chair, and other Members of the Committee who are cosponsors of H.R. 5, for providing a much needed focus for action at the national level.

I am Donald Palmisano, MD, JD, President-elect of the AMA and a general and vascular surgeon from New Orleans, LA. The policy of the AMA is decided through its democratic policy-making process in the AMA House of Delegates, which meets twice a year. Our House is comprised of physician delegates representing every state, nearly 100 national medical specialty societies, federal service agencies (including the Surgeon General of the United States), and six sections representing hospital and clinic staffs, resident physicians, medical students, young physicians, medical schools, and international medical graduates. AMA policy dictates support for national medical liability reform. In particular, the AMA supports H.R. 5, the HEALTH Act.

Mr. Chair, you know that our health care system is facing a crisis when patients have to leave their state to receive urgent surgical care. You know that our health care system is facing a crisis when pregnant women cannot find an OB/GYN to monitor their pregnancy and deliver their baby. You know that our health care system is facing a crisis when community health centers have to reduce their services or close their doors because of liability insurance concerns. You know that our health care system is facing a crisis when dedicated professionals, who have trained for years, want to give up the work of a lifetime and retire. You know that our health care system is facing a crisis when physicians and other health care professionals believe they work in a culture of fear, rather than a culture of safety. You know that our health care system is facing a crisis when efforts to improve patient safety and quality are stifled because of lawsuit fears. An unrestrained medical liability system is driving our health care system into crisis.

As you have recognized, the time for action is past due. Physicians across the country are making decisions now, and more and more patients are wondering, "Will their doctor be there?" We must act now to fix our broken medical liability system. That is why we are here supporting H.R. 5, and that is why we join with numerous other members of a broad-based coalition known as the Health Coalition for Liability and Access to urge this Congress to promptly reform the medical liability system.

ACCESS TO CARE IS AT RISK

The crisis facing our nation's medical liability system has not waned—in fact, it is getting worse. Escalating jury awards and the high cost of defending against law-

suits, even frivolous ones, have caused medical liability insurance premiums to reach unprecedented levels. As a result, a growing number of physicians can no longer find or afford liability insurance. Over the past two years, many physicians have been hit with medical liability premium increases of 25 to 400 percent. Some hospitals have seen premiums increase 140 percent in the same time period.

The most troubling aspect of this crisis is its impact on patients. As insurance becomes unaffordable or unavailable, physicians are being forced to close their practices or drop vital services—all of which seriously impede patient access to care. Emergency departments are losing staff and scaling back certain services such as trauma units. Many obstetrician-gynecologists and family physicians have stopped delivering babies, and some advanced and high-risk procedures (such as neurosurgery) are being postponed because physicians can no longer afford or even find the liability insurance they need to practice. According to the American Hospital Association's 2002 TrendWatch 1, more than 26% of health care institutions have reacted to the liability crisis by cutting back on services, or even eliminating some units.

**A 2002 survey conducted by Wirthlin Worldwide shows that 78 percent of Americans say they are concerned about access to care being affected because doctors are leaving their practices due to rising liability costs.**

Virtually every day for the past year there has been at least one major media story on the plight of American patients and physicians as the liability crisis reaches across the country. Access to health care is now seriously threatened in states such as Florida, Georgia, Mississippi, Nevada, New Jersey, New York, Ohio, Oregon, Pennsylvania, Texas, Washington, and West Virginia. On top of this, we expect at least five more states to be in a full blown crisis in the near future, with a crisis looming in at least 26 other states. A sample of media reports in the appendices to this testimony illustrates the problems faced by patients and physicians in some of these states—problems many other states will face if effective tort reforms are not enacted.

**We must bring common sense back to our courtrooms so that patients have access to their emergency rooms, delivery rooms, operating rooms, and physicians' offices.**

THE LITIGATION SYSTEM IS CAUSING THE CRISIS

The primary cause of the growing liability crisis is the unrestrained escalation in jury awards that are a part of a legal system that in many states is simply out of control. While there have been several articles published since the mid-1990s indicating that increases in jury awards lead to higher liability premiums, in the last year a growing number of government and private sector reports show that increasing medical liability premiums are being driven primarily by increases in lawsuit awards and litigation expenses.

In his State of the Union Address last month, President Bush stressed that we all are threatened by a legal system that is out of control. The President stated that "Because of excessive litigation, everybody pays more for health care and many parts of America are losing fine doctors." The President's remarks are substantiated in several recent government and private sector reports—reports making clear that the medical liability litigation system in the United States has evolved into a "lawsuit lottery," where a few patients and their lawyers receive astronomical awards and the rest of society pays the price as access to health care professionals and services are reduced.

*RECENT FEDERAL GOVERNMENT REPORTS*

In a July 2002 report released by the U.S. Department of Health and Human Services (HHS), the federal government concluded that the excesses of the litigation system are threatening patients' access to health care. This federal government report states that insurance premiums are largely determined by the litigation system, and that the litigation system is inherently costly, unpredictable, and slow to resolve claims. **Just to defend a claim now costs on average over $24,000. Further, the fact that about 70 percent of claims end with no payment to the patient indicates the degree to which substantial economic resources are being squandered on fruitless legal wrangling**—resources that could be used to reduce health costs so that more Americans could find health insurance.

Even when there is a large award in favor of an injured patient, a large percentage of the award never reaches the patient. Attorney contingent fees, added with court costs, expert witness costs, and other "overhead" costs, can consume 40–50 percent of the compensation meant to help the patient.

On September 25, 2002, HHS issued an update on the medical liability crisis. This update reported on the results of a survey conducted by Medical Liability Monitor

(MLM), an independent reporting service that tracks medical professional liability trends and issues. According to MLM, the survey determined that the crisis identified in HHS's July report had become worse. The federal government reported that:

> The cost of the excesses of the litigation system are reflected in the rapid increases in the cost of malpractice insurance coverage. Premiums are spiking across all specialties in 2002. When viewed alongside previous double-digit increases in 2000 and 2001, **the new information further demonstrates that the litigation system is threatening health care quality for all Americans as well as raising the costs of health care for all Americans.** (emphasis added)

This federal government update further highlights that liability insurance rates are escalating faster in states that have not established reasonable limits on unquantifiable and arbitrary non-economic damages. The government's report states that:

> . . . 2001 premium increases in states without litigation reform ranged from 30–75%. In 2002, the situation has deteriorated. **States without reasonable limits on non-economic damages have experienced the largest increases by far, with increases of between 36–113% in 2002.** States with reasonable limits on non-economic damages have not experienced the same rate spiking. (emphasis added)

HHS also compared the range of physician liability insurance premiums for certain specialties in California, which has established reasonable limits on awards for non-economic damages, to the premiums in states that have not enacted similar limits. The results reveal how excessive awards for non-economic damages affect premiums. For example, in 2002, OB/GYNs in California paid up to $72,000 in medical liability premiums. In Florida, which does not limit non-economic damage awards, OB/GYNs paid up to $211,000 for liability coverage.

Further, a 2002 Congressional Budget Office study on H.R. 4600 (107th Congress), which included a limitation on non-economic damages, asserts that:

> CBO's analysis indicated that certain tort limitations, primarily caps on awards and rules governing offsets from collateral-source benefits, effectively reduce average premiums for medical malpractice insurance. Consequently, CBO estimates that, in states that currently do not have controls on malpractice torts, H.R. 4600 would significantly lower premiums for medical malpractice insurance from what they would otherwise be under current law.

In Florida, as indicated in the example given above, medical liability premiums are among the highest in the nation. The situation in Florida has become so dire that Governor Bush created a special Task Force to examine the availability and affordability of liability insurance. This Task Force held ten hearings over a five month period and received extensive testimony and information from numerous, diverse sources.

Among the many findings in its report released on January 29, 2003, **the Governor's Task Force found that the level of liability claims paid was the main cause of the increases in medical liability insurance rates.** The Task Force ultimately concluded that "the centerpiece and the recommendation that will have the greatest long-term impact on healthcare provider liability insurance rates, and thus eliminate the crisis of availability and affordability of healthcare in Florida, is a $250,000 cap on non-economic damages."

*RECENT PRIVATE SECTOR REPORTS*

Evidence that the litigation system is broken, and that the medical liability crisis is growing, is further established in a study released by Tillinghast-Towers Perrin on February 11, 2003. Tillinghast reported that "The cost of the U.S. tort system grew by 14.3% in 2001, the highest single-year percentage increase since 1986," which is "equivalent to a 5% tax on wages." This is the only study that tracks the cost of the U.S. tort system from 1950 to 2001 and compares the growth of tort costs with increases in various U.S. economic indicators. Some of the key findings of this study are stunning:

- The U.S. tort system is a highly inefficient method of compensating injured parties, returning less than 50 cents on the dollar to people it is designed to help and returning only 22 cents to compensate for actual economic loss.
- As of 2001, U.S. tort costs accounted for slightly more than 2% of GDP, signaling an increase after a 13-year decline in the ratio of tort costs to GDP.

- While the cost of the U.S. tort system has increased one hundred fold over the last fifty years, GDP has grown by a factor of only 34.
- **Medical malpractice costs have risen an average of 11.6% a year since 1975 in contrast to an average annual increase of 9.4% for overall tort costs, outpacing increases in overall U.S. tort costs.**

The study also adds that "These trends continued in 2002, with no sign of abatement in the near future." In a press release accompanying this study, a Tillinghast principal stated that, "Absent sweeping tort reform measures, we expect most of these trends to continue in 2003 and beyond."

In a 2001 report by Jury Verdict Research, data show that in just a one year period (between 1999 and 2000) the median jury award increased 43 percent. Further, median jury awards for medical liability claims grew at 7 times the rate of inflation, while settlement payouts grew at nearly 3 times the rate of inflation. Even more telling, however, is that **the proportion of jury awards topping $1 million increased from 34 percent in 1996 to 52 percent in 2000. More than half of all jury awards today top $1 million, and the average jury award has increased to about $3.5 million.**

These are just a few examples of growing evidence that reveal that out-of-control jury awards are inexorably linked to the severe increases in medical liability insurance premiums. It is clear that corrective action through federal legislation is urgently needed.

*BLAMING INSURANCE INDUSTRY INVESTMENTS IS A RED HERRING*

Organizations opposing H.R. 5 have claimed that soaring medical liability insurance premiums are the result of declining investments in the insurance industry, and that liability reforms do not stabilize the insurance market. The reports discussed above, as well as several other authoritative and credible studies, reveal such claims to be misleading, based on flawed analysis, and contrary to the facts.

Last month, Brown Brothers Harriman & Co. (BBH) released a report ("Did Investments Affect Medical Malpractice Premiums?") that analyzed the impact of insurers' asset allocation and investment income on the premiums they charge. **BBH concluded that there is no correlation between the premiums charged by the medical liability insurance industry, on the one hand, and the industry's investment yield, the performance of the U.S. economy, or interest rates, on the other hand.**

In addition, on February 4, 2003, BBH released an addendum to this study that analyzed National Association of Insurance Commissioners (NAIC) data to determine whether investment gains by medical liability insurance companies declined in the recent bear market. BBH asked the question: "Did medical malpractice companies raise premiums because they had come to expect a certain percentage gain that was not achieved due to market conditions?" BBH determined that the decline in equities (which are a small percentage of insurance company investments) was more than offset by the capital gains by bonds (which make up a substantial part of insurance company investments) due to a decline in interest rates. **BBH concluded that "investments did not precipitate the current crisis."**

BBH's findings are corroborated by other recent reports. On September 25, 2002, HHS released an update on the medical liability crisis addressing claims that the crisis is caused by the management practices of the insurance industry. HHS concluded that such claims are not supported by facts, stating "**Comparisons of states with and without meaningful medical liability reforms provide clear evidence that the broken medical litigation system is responsible."**

In addition, a summary of medical liability insurer annual statement data in A.M. Best's Aggregates & Averages, Property-Casualty, 2002 edition shows that the investment yields of medical malpractice insurers have been stable and positive since 1997. A.M. Best reports that medical liability insurers have approximately 80% of their investments in the bond market. Also, **recent NAIC data show that physicians' medical liability insurance premiums between 1976–2000 have risen 167% in California (which established effective liability reforms in 1975) compared to 505% in the rest of the United States.**

The report on which H.R. 5 opponents base most of their speculations, produced under the direction of J. Robert Hunter for the Americans for Insurance Reform (AIR), is flawed in a number of ways. The AIR/Hunter study purports that there is no current explosion in medical liability insurance payouts, and that the explosion in medical liability insurance premiums is due to the insurance underwriting cycle. While *medical liability insurance premiums, medical liability award payouts*, and *tort law factors* differ across states, the premium and payout data presented in AIR's report are at the national level. One cannot use national data to draw valid

conclusions about how state-specific changes in premiums may be related to state-specific changes in payouts. **Conclusions about what has or has not caused recent premium escalation without accounting for the state-level factors listed above are unsupportable.**

In addition to claiming that the current medical liability crisis is an insurance issue, there have been attempts to argue that medical liability insurance premium rates in California have remained stable because of Proposition 103, not because of the successful medical liability reforms (known as MICRA-discussed later) that have been in place in California since 1975. Such claims are misguided. Proposition 103, also known as the Insurance Rate Reduction and Reform Act, applies to all lines of insurance, not just medical liability insurance. It was passed as an initiative by the voters in 1988 (thirteen years after MICRA), yet did not take effect until 1989. This is when the state's high court struck down its rate rollback provisions while maintaining the remainder of the law.

Proposition 103 implemented a basic standard that "no rate shall be approved or remain in effect which is excessive, inadequate, unfairly discriminatory or otherwise in violation of this chapter." However, Proposition 103 provides that "every insurer which desires to change any rate shall file a complete rate application with the commissioner." Proposition 103 also requires that the Department of Insurance grant a hearing for a challenge to any increase above 15 percent for commercial lines of insurance.

According to Californians Allied for Patient Protection, "Insurers have regularly applied for and obtained significant rate increases in all lines of insurance, except medical liability where MICRA has kept the rates from rising astronomically. Between September and the end of October, 2002, for instance, the Insurance Department approved more than 75 applications for double-digit increases in insurance rates." **None of these approved increases included medical liability insurance.** This illustrates that Proposition 103 is not responsible for keeping medical liability premiums down. Rather, as we discuss later, it is MICRA that has been the force behind California's success.

Such misdirected claims as discussed above are a disservice to patients who are losing access to health care services, and an affront to the physicians and other health care professionals who dedicate their lives to healing and caring for the sick and working to find ways to improve the quality of care. America's medical liability crisis is too serious and the consequences of inaction too grave for the public and Congress to use anything but the facts to make decisions about reform. In short, these claims are counterproductive to the debate on resolving the medical liability crisis.

*FEDERAL SOLUTION*

The medical liability crisis is a growing national problem that requires a national solution. If the crisis was just a matter of physicians obtaining or affording medical liability insurance in one state, we might agree that a national approach would not necessarily be required. However, the problem goes far beyond physicians and other health care professionals and institutions. The medical liability crisis has become a serious problem for patients and their ability to access health care services that would otherwise be available to them, including services provided to Medicare and Medicaid patients.

Also, the premise that it is within the ability of every state to enact legislation to effectively resolve their respective medical liability crisis has been shattered by the fact that many state liability reform laws have been nullified by activist state courts or stripped of their most effective provisions under state constitutions that limit reforms. Taking into consideration that studies show the litigation system to be an ineffective, and often unfair, mechanism for resolving medical liability claims, we believe that the time is ripe for a uniform, federal approach to resolving the liability crisis.

Moreover, there is a direct and compelling federal interest in reforming our outmoded medical liability system. According to estimates by HHS, altogether medical liability adds $60 billion to $108 billion to the cost of health care each year. This means higher health insurance premiums and higher medical costs for all Americans, and especially for the federal government given that one-third of the total health care spending in our country is paid by the Medicare and Medicaid Programs. Further, HHS estimates that excessive medical liability adds $47 billion annually to what the federal government pays for Medicare, Medicaid, the State Children's Health Insurance Program, Veterans' Administration health care, health care for federal employees, and other government programs.

*THE LIABILITY CRISIS AND PATIENT SAFETY*

The AMA's policy is to be part of the solution to improving patient safety and quality. The AMA believes that one preventable error is one error too many. In fact, the AMA helped launch the National Patient Safety Foundation (NPSF) in 1996 to address patient safety issues, well before publication of the IOM report. The NPSF's approach is to create a culture of cooperative learning and mutual improvement, as opposed to a culture of shame and blame.

Quality of care improves when there is greater access to physicians and health care services. A culture of safety requires a legal environment that encourages professionals and organizations to work together to identify problems in providing care, evaluate the causes, and use that information to improve care for all patients. An over-litigious system is anathema to building a strong and effective national patient safety program.

Under our current liability system, the reality of being sued is daunting to just about everyone in the medical community. A 2002 Harris Interactive study *(The Fear of Litigation Study—The Impact on Medicine)* illustrates just how detrimental the litigious nature of our society is to physicians and other health care professionals. This study reveals the extent to which the fear of litigation affects the practice of medicine and the delivery of health care—"From the increased ordering of tests, medications, referrals, and procedures to increased paperwork and reluctance to offer off-duty medical assistance, the impact of the fear of litigation is far-reaching and profound."

The study shows, among other things, that more than three-fourths (76%) of physicians believe that concern about medical liability litigation has negatively affected their ability to provide quality care in recent years, and nearly all physicians and hospital administrators feel that unnecessary or excessive care is provided because of litigation fears. It also shows that an overwhelming majority of physicians (83%) and hospital administrators (72%) do not trust the current system of justice to achieve a reasonable result to a lawsuit.

The Harris study found that a majority (59%) of physicians believe ("a lot") that the fear of liability discourages open discussion and thinking about ways to reduce health care errors. The AMA has long believed that health professionals and organizations should be encouraged to report and evaluate health care errors and to share their experiences with others in order to prevent similar occurrences. However, this "culture of fear" caused by our over-litigious society suppresses such information.

The AMA strongly supports the principle underlying the 1999 Institute of Medicine (IOM) report entitled, *To Err is Human: Building a Safer Health System*, that the health care system needs to transform the existing culture of blame and punishment, which suppresses information about errors, into a "culture of safety" that focuses on openness and information-sharing to improve health care and prevent adverse outcomes. The AMA also supports the IOM's focus on the need for a system-wide approach to eliminating adverse outcomes and improving safety and quality, instead of focusing on individual components of the health system in an isolated or punitive way.

Toward this end, the AMA supports H.R. 663, the "Patient Safety and Quality Improvement Act," which was favorably reported by the House Energy & Commerce Committee on February 12, 2003. H.R. 663 would provide a framework to create a "culture of safety" by establishing a confidential, non-punitive, and evidence-based system for reporting health care errors. There is a very broad and strong consensus of agreement on this legislative approach within the health care community. By implementing this approach, errors can be identified and analyzed to improve patient safety by preventing future errors.

In addition to patient safety and quality improvement, the fear of litigation stifles the advancement of new medical treatments and medications, encourages physicians to practice defensive medicine, overwhelms the health care system with paperwork—leaving less time for patient care, and discourages qualified candidates from pursuing a career in medicine or from moving to a state with a bad liability climate.

*THE PRACTICAL SOLUTION*

The AMA recognizes that injuries due to negligence do occur in a small percentage of health care interactions, and that they can be as devastating or worse to patients and their families than injury due to natural illness or unpreventable accident. When injuries occur and are caused by a breach in the standard of care, the AMA believes that patients are entitled to prompt and fair compensation.

This compensation should include, first and foremost, full payment of all out of pocket "economic" losses. The AMA also believes that patients should receive reasonable compensation for intangible "non-economic" losses such as pain and suffering and, where appropriate, the right to pursue punitive damages.

Unfortunately, our medical liability litigation system is neither fair nor cost effective in making a patient whole. Transformed by high-stakes financial incentives, it has become an increasingly irrational "lottery" driven by open-ended non-economic damage awards. As mentioned above, studies show that our tort system, in general, is an extremely inefficient mechanism for compensating claimants—returning less than 45 cents on the dollar to claimants and only 20 cents of tort cost dollars to compensate for actual economic losses.

To ensure that all patients who have been injured through negligence are fairly compensated, the AMA believes that Congress must pass fair and reasonable reforms to our medical liability litigation system that have proven effective. Toward this end, **we strongly urge Congress to pass the "Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act,"** a bipartisan bill that would bring balance to our medical liability litigation system.

The major provisions of the HEALTH Act would benefit patients by:

- Awarding injured patients *unlimited* economic damages (e.g., past and future medical expenses, loss of past and future earnings, cost of domestic services, etc.);
- Awarding injured patients non-economic damages up to $250,000 (e.g., pain and suffering, mental anguish, physical impairment, etc.), with states being given the flexibility to establish or maintain their own laws on damage awards, whether higher or lower than those provided for in this bill;
- Awarding injured patients punitive damages up to $250,000 or up to two times economic damages, whichever is *greater;*
- Establishing a "fair share" rule that allocates damage awards fairly and in proportion to a party's degree of fault; and
- Establishing a sliding-scale for attorneys' contingent fees, therefore maximizing the recovery for patients.

These reforms are not part of some untested theory—they work. The major provisions of the HEALTH Act are based on the successful California law known as MICRA (Medical Injury Compensation Reform Act of 1975). MICRA reforms have been proven to stabilize the medical liability insurance market in California—increasing patient access to care and saving more than $1 billion per year in liability premiums—and have reduced the time it takes to settle a claim by 33 percent. MICRA is also saving California from the current medical liability insurance crisis brewing in many states that do not have similar reforms. In fact, according to MLM, as discussed above, the gap between medical liability insurance rates in California and those in the largest states that do not limit non-economic awards is substantial and growing.

MICRA-type reforms are effective, especially at controlling non-economic damages. Several economic studies substantiate this point. One study looked at several types of reforms and concluded that capping non-economic damages reduced premiums for general surgeons by 13% in the year following enactment, and by 34% over the long term. Similar results were shown for premiums paid by general practitioners and OB/GYNs. It was also shown that caps on non-economic damages decrease claims severity (i.e., amount of the claim) (Zuckerman et al. 1990).

Another study published in the *Journal of Health Politics, Policy and Law* concluded that caps on non-economic damages reduced insurer payouts by 31%. Caps on total damages reduced payouts by 38% (Sloan, et al. 1989). Another study concluded that states adopting direct reforms experienced reductions in hospital expenditures of 5% to 9% within three to five years. If these figures are extrapolated to all medical spending, a $50 billion reduction in national health spending could be achieved through such reforms (Kessler and McClellan, *Quarterly Journal of Economics*, 1997).

Further, as discussed above, a 2002 Congressional Budget Office study on H.R. 4600 (107th Congress) asserts caps on non-economic damages have been *extremely effective in reducing the severity of claims and medical liability premiums*. Conversely, a 1996 American Academy of Actuaries study shows that *medical liability costs rose sharply* in Ohio after the Ohio Supreme Court overturned a liability reform law in the 1990s that set limits on non-economic damages. (Ohio recently enacted a new liability reform law.)

Furthermore, a Gallup poll released on February 5, 2003, show that 72% of those polled favor a limit on the amount patients can be awarded for pain and suffering. This Gallup poll is consistent with a 2002 survey conducted by Wirthlin Worldwide showing that three-quarters of Americans understand the detrimental effect that excess litigation has on our health care system. The Wirthlin survey shows that the vast majority of Americans agree we need common sense medical liability reform.

In addition to the 78 percent discussed above who said that they are concerned about access to care, the survey found that:

- 71 percent of Americans agree that a main reason health care costs are rising is because of medical liability lawsuits.
- 73 percent support reasonable limits on awards for "pain and suffering" in medical liability lawsuits.
- More than 76 percent favor a law limiting the percentage of contingent fees paid by the patient.

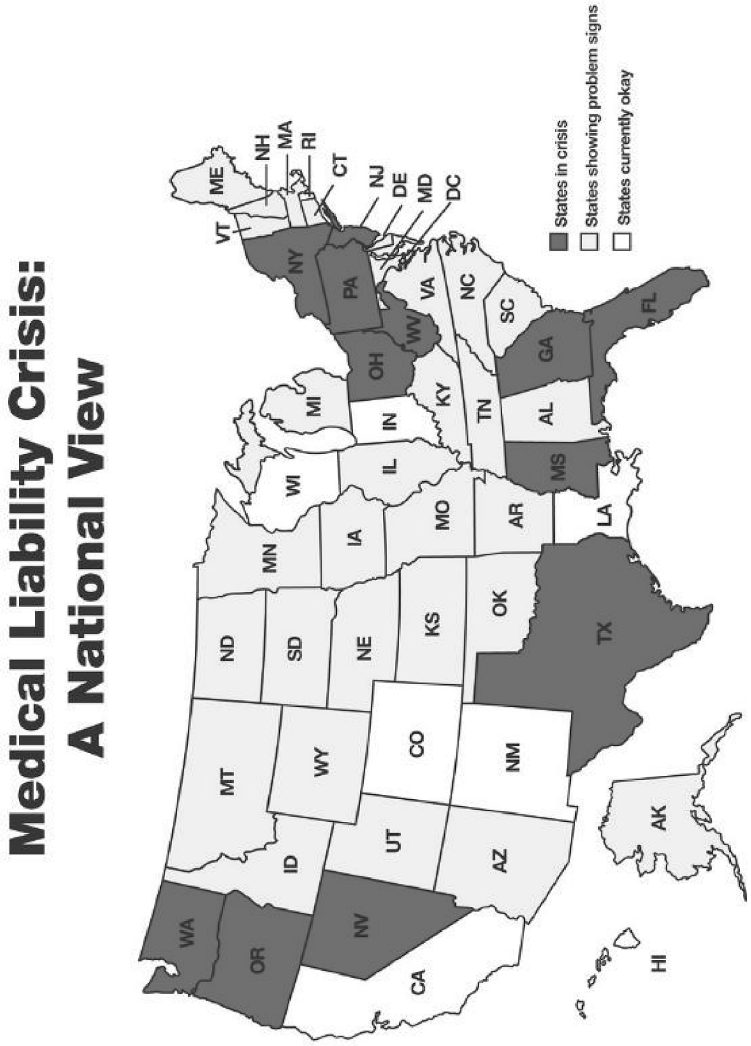
*CONCLUSION*

Physicians and patients across the country realize more and more every day that the current medical liability situation is unacceptable. Unless the hemorrhaging costs of the current medical liability system are addressed at a national level, patients will continue to face an erosion in access to care because their physicians can no longer find or afford liability insurance. The reasonable reforms of the HEALTH Act have brought stability in those states that have enacted similar reforms.

By enacting meaningful medical liability reforms, Congress has the opportunity to increase access to medical services, eliminate much of the need for medical treatment motivated primarily as a precaution against lawsuits, improve the patient-physician relationship, help prevent avoidable patient injury, and curb the single most wasteful use of precious health care dollars—the costs, both financial and emotional, of health care liability litigation. The modest proposals in the HEALTH Act answer these issues head on and would strengthen our health care system.

The AMA appreciates the opportunity to testify on the adverse effect that our current medical liability litigation system imposes on patient access to health care and urges Congress to pass H.R. 5, the HEALTH Act.

**Appendix A**


Medical Liability Crisis:
A National View
States in crisis
States showing problem signs
States currently okay
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## APPENDIX B

### MEDICAL LIABILITY CRISIS AFFECTS ACCESS TO CARE

### CRISIS STATES

#### THE MEDICAL LIABILITY CRISIS—A NATIONWIDE PROBLEM

*Florida*

- Women are facing waiting lists of four months before being able to get an appointment for a mammogram because at least six mammography centers in South Florida alone have stopped offering the procedure as a result of increasing medical liability insurance premiums. "This trend is troubling. There are a growing number of older people and less and less people to provide mammograms," said Jolean McPherson, a Florida spokeswoman for the American Cancer Society. *South Florida Sun Sentinel, Nov. 4, 2002.*
- Aventura Hospital in South Florida closed its maternity ward and cited $1,000 in insurance premiums for each delivery as the prime factor. Aventura is one of six maternity wards to close in recent months. Now, patients will be forced to drive to other counties and other facilities. "There may be waits getting into a labor-room floor," said OB/GYN Aaron Elkin, MD. *Miami Herald, Oct. 19, 2002.*
- "Without a doubt, access to health coverage is being affected. Some of our emergency rooms are losing their effectiveness," said Dr. Greg Zorman, neurosurgery chief at Memorial Regional Hospital in Hollywood. His unit gets several patients a week from smaller ERs that have lost neurosurgery coverage. *South Florida Sun Sentinel, February 5, 2003.*
- Port Charlotte cardiologist Leonardo Victores, MD, left for Kansas in the face of medical liability premiums that were going to increase 100 percent. "He's moving to Kansas because that state has caps on malpractice awards," said colleague Mark Asperilla, MD. *Sun Herald, Jan. 1, 2003.*
- Despite having no malpractice claims or disciplinary actions on his record, Lakeland OB/GYN John Kaelber, MD, was forced to close his practice and leave the state in the wake of insurance premiums that doubled. *Lakeland Ledger, Nov. 21, 2002.*
- More than 50 Bradenton patients had to postpone elective surgeries and more than 100 office visits were canceled because two physicians were unable to obtain liability insurance. The insurer may leave the state altogether. *Bradenton Herald, Jan. 24, 2003.*
- After recently receiving notice of a premium spike coming in July 2002, Vladimir Grnja, MD, decided that he would "go bare" and drop all medical liability insurance coverage. Rates for the Hollywood, FL radiologist were to rise to $112,000 from $35,000 a year (a 220% increase), mainly because of litigation over mammograms. "No doctor wants to go bare," said Dennis Agliano, MD, chairman of the Florida Medical Association's special task force on the Florida medical liability crisis. But with significant premium hikes in Florida for specialties like OB/GYN, neurosurgery, thoracic surgery, radiology and even primary care, "some doctors have no choice," he says. Some neurosurgeons in South Florida, are paying a $200,000 premium for coverage of $250,000 per occurrence, making insurance practically meaningless. The Florida Medical Association reports that more than 1,000 doctors in Florida have no medical liability insurance. Doctors in West Virginia and Ohio are also reportedly going bare. *Modern Physician, April 1, 2002.*
- Ob/Gyns in the "Sunshine State" face the highest premiums in the nation, some as high as $208,000. Many surgeons also are facing premiums in excess of $200,000.
- Fourteen of the 16 neurosurgeons in Broward County cannot afford insurance and are going "bare." Neurosurgeons in Pinellas County are considering doing the same rather than face increases of 55 percent or greater to more than $100,000.
- The *Miami Herald* reports one radiologist saw his premiums increase from $32,000 to $112,000 in one year due to "mushrooming lawsuits involving mammograms." Another radiologist told the *St. Petersburg Times* he would no longer read mammograms because of the high risk of being sued.
- Cardiologists and internists also are seeing insurance rates double or triple this year.

- An insurance executive told the South Florida *Sun-Sentinel* that insurance companies are paying out $1.30 for every $1.00 they collect in premiums, a fact that cries out for medical liability reform.
- And, what's worse $100,000 only buys about $1 million in coverage, a small amount compared to soaring jury verdicts. *Tallahassee Democrat, June 30, 2002.*
- PHICO, the third largest professional liability insurer in Florida was forced into liquidation earlier this year. Zurich American Insurance Co., and Clarendon National also are leaving the Florida market. Remaining insurers are on record as saying they will draw sharper lines between which physician specialty they will and will not insure.
- Florida's community hospitals are considering the drastic step of no longer requiring physicians to carry professional liability insurance to ensure the hospitals can remain open.
- "The squeeze is hitting South Florida extremely hard, and it's gradually spreading out to the rest of the state," Dennis Agliano, MD, FMA secretary and chair of its tort reform task force. *(The South Florida Business Journal)*
- Several Florida Supreme Court rulings have weakened tort reforms in Florida.
- "Litigation was and always will be the problem in Florida until there are caps," said Bob White, COO of First Professionals Insurance Co., Florida's largest carrier.
- Medical Specialists of the Palm Beaches, a 50-physician group, saw its premiums rise from $800,000 to $2.5 million this year.
- American Physicians Assurance announced on July 17, 2002 that it is leaving the state
- Farmer's Insurance has announced its intent to leave the state. Among other insurers, MAG is still writing policies, while Medical Protective and ProNational are being very selective. FPIC, the largest medical liability carrier in the state, endorsed by FMA, is only writing very selectively. Both Clarendon and St. Paul have pulled out entirely.
- According to the FMA's General Counsel, Florida's existing caps simply do not work and are never used. The caps only apply in cases where the physician agrees to arbitration and in order for the case to go to arbitration the physician must admit liability. In addition, the original intent of this Florida provision was to have the cap apply to each incident, but it has been interpreted to apply to per claimant, which obviously also decreases its effectiveness. The lack of a straight cap is the primary reason for the current crisis in Florida. Unlike such States as Kansas, Florida, has not seen an increase in frequency of claims, but there has been an increase for severity in jury awards.
- In a presentation before FMA, the medical liability insurance carrier, EPIC, presented facts that demonstrate the medical liability crisis in Florida. During 1975, there were 380 health care lawsuits in Florida, resulting in $10.8 million in jury awards and costing $1.5 million to defend. In 2000 there were 880 lawsuits alleging malpractice, resulting in awards of $219 million and costing $36 million to defend.
- Dr. Oliver Bayouth says his medical-malpractice premiums are skyrocketing. The Orlando obstetrician is paying about $100,000 for insurance this year, up at least 25 percent from two years ago. Frustrated, Bayouth says he is thinking about moving his practice out of Florida. *Orlando Sentinel, January 20, 2002.*
- In South Florida, where insurers say litigation is the heaviest, ob/gyns pay as much as $202,949 a year—the highest rates in the country, according to Medical Liability Monitor, a Chicago-based newsletter. Orlando Sentinel, January 20, 2002.
- Dr. Alan Appley, an Orlando neurosurgeon, moved his practice to Lafayette, Louisiana, last year in part to escape Florida's soaring malpractice rates. Orlando Sentinel, January 20, 2002.
- Dr. Joseph Boyer, an Orlando cardiologist, says his rates rose 64.6 percent, to $99,000, in 2002. Orlando Sentinel, January 20, 2002.
- Central Florida Cardiothoracic Surgery in Orlando says it will pay about $140,000 to insure two surgeons in 2002, compared with about $54,000 last year. *Orlando Sentinel, January 20, 2002.*
- Dr. Alexander Jungreis, an Orlando neurosurgeon, said his liability insurance premiums tripled this year. *Orlando Sentinel, January 20, 2002.*

- Dr. Jorge Perez, an Orlando internist, said his insurer canceled his policy last year even though he never had a claim filed against him. His new company is charging him $18,000 per year, compared with the $11,000 he previously paid, on top of a $25,000 fee to cover possible lawsuits from prior incidents. *Orlando Sentinel, January 20, 2002.*
- Nationwide, one out of every 12 doctors gets sued each year, while in Florida it's one out of every six, said Bob White, chief operating officer of Jacksonville-based First Professionals Insurance Co., the state's largest provider of medical liability insurance with about 33 percent of the market. *Orlando Sentinel, January 20, 2002.*

*Georgia*

- According to a Georgia Board for Physician Workforce study released in January 2003, 2,800 physicians in Georgia are expected to stop providing high-risk procedures to limit medical liability.
- The study also indicated that 1,750 physicians reported that have stopped or plan to stop providing ER coverage and 630 physicians plan to quit practicing or leave the state. In addition, 1 in 5 family physicians and 1 in 3 Ob-Gyns reported plans to stop providing high-risk procedures, including delivering babies.
- But numbers alone do not tell the whole story; there is a very human side to this crisis. For instance, although she is only in her first year of medical school at Medical College of Georgia, the liability crisis has already caused Thandeka Myeni, 26, to reconsider her preference for obstetrics, one of the specialties hardest hit by medical liability increases. "I definitely think it could be discouraging," she said. *The Augusta Chronicle, Nov. 13, 2002.*
- Evans Memorial, a rural hospital in Claxton, decided to "go bare"—have no coverage at all-instead of paying what it considered an exorbitant medical liability premium. Only one insurer offered a malpractice policy for the hospital and its nursing home, and the annual premium for $1 million in coverage would have been $581,000, up from $216,000 last year. "We just thought it was outrageous," said Eston Price, Evans Memorial administrator. *The Atlanta Journal-Constitution, Oct. 7, 2002.*
- The largest hospital in the state's health system has bought a new policy—with a deductible of $15 million—covering 953-bed Grady Memorial, a nursing home and clinics. On each paid claim below that mark, Grady is responsible for every dollar. The $15 million deductible starts again with each claim. "Grady faces open-ended liability," said Timothy Jefferson, Grady Health System executive vice president and chief counsel. *The Atlanta Journal-Constitution, Oct. 7, 2002.*
- Knowing that malpractice premiums were rising for everyone in the industry, Ty Cobb Health System CEO, Chuck Adams earmarked enough money for a 100 percent increase. The bill arrived by fax this summer, just 24 hours before a check was due. Not only was the insurance company increasing his deductible tenfold, but the premium jumped from $553,000 to $3.15 million—a 469 percent increase. "We were numb," said Adams, who eventually got an extension and another cheaper policy at $1.65 million. "There goes our expansions, like a renovation of the Hart County Emergency Room." *The Atlanta Journal-Constitution, Aug. 11, 2002.*
- "Dr. Edmund Wright, a Fitzgerald family practitioner who performed Caesarian sections, has given up that part of his practice. His premiums quadrupled to $80,000 in 2002 and would have been $110,000 if he had continued the surgical delivery procedure." Wright said, "I don't know if I really want to do this anymore." *The Atlanta Journal-Constitution, Aug. 11, 2002.*
- Insurance costs are rising so high and so quickly because of medical malpractice lawsuits that many doctors are quitting medical practice, said Michael Greene, who has a family practice in Macon. The problem is increasing so fast that Georgia will soon face a critical shortage of physician, Greene said. "It hasn't hit with a tidal wave yet, but the waves are beginning to lap at the shore," Greene continued. *The Macon Telegraph, Aug. 3, 2002.*
- David Cook, executive director of the Medical Association of Georgia, said the malpractice crisis is driving more doctors into early retirement. "One-third of doctors 55 and older say they plan to reduce their hours or get out altogether," he said. "These are physicians at the peak of their diagnostic powers." *The Times (Gainesville), July 17, 2002).*
- 40 percent of the State's hospitals have seen have seen medical liability premium go up 50 percent or more in 2002. A rural hospital in Bainbridge actually faced increases from $140,000 to $970,000.

- St. Paul was the second largest carrier in Georgia before its pull-out. The remaining insurers are raising rates for some specialties by 70 percent or greater. Some ER physicians, Ob-Gyns and radiologists have not yet found new coverage.
- On average, Georgia physicians are facing premium increases of 30 percent or greater for 2002.
- Georgia physicians paid more than $92,000,000 to cover jury awards for 2000. That amount was the 11th highest in the nation despite Georgia ranking only 38th in total number of physicians in the United States.
- The median jury award increased from $225,000 in early 1990s to $480,000 by late 1990s.
- The number of paid claims totaling $1 million or more increased from one in 1990 to 13 in 2000. There was one claim of $2 million or more in 1991, and more than 5 so far in 2002; according to MAG Mutual, which insures 70% of Georgia physicians. *Atlanta Journal & Constitution Aug. 11, 2002*

*Mississippi*

- Although Mississippi enacted some medical liability reforms late last year, it is still too early to see if this will stem the exodus of physicians from the State. The reason: the Mississippi cap on non-economic damages has broad exceptions and the trial bar is looking for ways to get around its limits. In short, Mississippi remains in crisis.
- The Mississippi State Medical Association still estimates that the state could lose as many as 10 percent of its 4,000–4,500 physicians.
- Obstetricians in Mississippi still worry about what is going to happen to their patients who face longer trips to the hospital while already in labor. Women who used to walk or make a short drive for both prenatal visits and delivery now face a 45-minute drive by car to the only physician in their area who can still treat OB patients.
- Pregnant women who are considered high-risk, such as someone with diabetes, cannot be treated at the Kosciusko Medical Clinic because it is too risky for physicians, where seven physicians formerly practiced obstetrics and gynecology. Only three were predicted to remain in January 2003. *The Clarion-Ledger, Aug. 26, 2002.*
- Only two neurosurgeons remain in practice in the Gulf Coast-area of Mississippi, and general surgeons are in short supply because of the state's medical liability crisis. "Everybody is reduced to the same low level of trauma care that we had 20 years ago," said Steve Delahousey, vice president of operations at American Medical Response ambulance service. *Jan. 29, 2003 Biloxi Sun Herald*
- Neurologist Terry Smith, MD said he had applied with 14 companies, and Medical Assurance was his last hope to find coverage before his current policy expired on Aug. 4, 2002. His premium went from $55,000 a year to potentially $150,000 with a $132,000 tail to his old insurer. "I'm looking at writing a check for $300,000," said Smith, who does brain surgery at three hospitals in Jackson and Harrison counties. *Associated Press, July 11, 2002.*
- Four rural hospitals in Ocean Springs faced closure, as their insurer, Medical Assurance Company of Alabama, was not renewing their coverage because the insurer was leaving Mississippi.
- Greenwood Hospital—the only trauma center in a 55-mile radius—was unable to keep its Level-II trauma center rating because area neurosurgeons have left, citing the high cost of liability insurance. Greenwood also has lost 2 of its 4 Ob-Gyns.
- At least 15 insurers, including St. Paul, have left Mississippi in the previous five years.
- Nursing homes in Mississippi have faced insurance increases as high as 900 percent in the previous two years according to industry representatives.
- Tupelo has lost 3 of its 5 neurosurgeons in the previous two years because of the State's legal climate. A physician-delegate to the Mississippi Economic Council predicts nearly 100 physicians will leave Tupelo in the near future.
- In Cleveland, Mississippi, three of the town's six Ob-Gyns have stopped delivering babies. Yazoo City's 14,550 residents have no ob-Gyns. According to the Mississippi State Medical Association, insurance rates for Ob-Gyns have increased from 20—400 percent in the previous year.
- Since 1995, Mississippi has been home to 21 verdicts of $9 million or greater. Before 1995, there were none. In the first quarter of this year, $31 million was

awarded in such cases. The total for the entirety of last year was $32 million. *Daily Mississippean (Oxford, MS), July 30, 2002.*

- A Natchez doctor's group is seeking to build a $6 million medical office building across state lines in Louisiana rather than face continuing lawsuits and skyrocketing insurance premiums in Mississippi.
- Mississippi has been voted the nation's worst liability climate by the U.S. Chamber of Commerce, which has warned businesses away from doing business in the state. Rural areas are particularly hard hit by the state's liability crisis. Twenty-five of Mississippi's 80 counties have fewer physicians today than they did in 1990. 21 of those counties have 10 or fewer physicians.
- "The legislative process has slammed the proverbial door in the face of the entire business and medical communities," Mississippi's director of the National Federation of Independent Business told the Associated Press.
- Mississippi needs doctors like Kirk Kooyer, MD. He is the only pediatrician in Sharkey and Issaquena Counties, where the majority of patients live below the poverty level. Kooyer moved to the Mississippi Delta to serve those who cannot otherwise get medical treatment. Because of increasing litigation risks and high insurance premiums, Kooyer has decided to leave the Delta. His absence will put a strain on the community hospital because there is no pediatrician to take his place.
- In 2001, Bolivar County in western Mississippi had six physicians providing obstetrical care; today it has three. Obstetrics insurance for a doctor in Bolivar County jumped from $28,000 to $105,000, with a $25,000 deductible. *The Wall Street Journal, May 1, 2002*
- In neighboring Sunflower County, all four physicians who delivered babies have quit private practice. *The Wall Street Journal, May 1, 2002*
- In the northern half of the state last year there were nine practicing neurosurgeons; now there are just three on emergency call. *The Wall Street Journal, May 1, 2002*
- In 1998, 227 Mississippians filed malpractice suits. Based on the suits filed during the first quarter of 2002, the Medical Association Company of Mississippi predicts over 550 medical liability suits will be filed this year.
- Across the State, there is a veritable litigation explosion, in Jefferson County, for example, there are only about 9,740 residents—but the number of lawsuits filed in 1999 numbered 10,000. A year later, in 2000, the number of plaintiffs on the docket increased to 27,000, or nearly three times the number of residents. *The Washington Times, May 11, 2002.*

*Nevada*

- In August, Nevada Governor Guinn called a special legislative session to address medical liability issues. In just four days, Nevada legislators enacted a meaningful liability reform bill.
- Unfortunately, while Nevada passed needed reforms, the crisis there has not yet been averted due to continued lack of availability and affordability of medical liability insurance. Insurers in Nevada have not yet reduced their premiums and physicians are still leaving the state, particularly in Southern Nevada.
- Why? Because the trial bar has threatened to institute legal challenges to this new law that could thwart and delay its implementation. Without the full force and effect of reforms right now, the scenario that has crippled access to medical care in Nevada will continue.
- 60 percent of Las Vegas-area Ob-Gyns have said they would stop delivering babies in 2002 because of the out-of-control legal system and skyrocketing liability premiums.
- Las Vegas' only trauma center, which treated more than 11,000 patients in 2001, closed for 10 days in July 2002 because it did not have enough surgeons to staff the center.
- When a trauma center closes, "some patients are going to die that wouldn't die . . . the quicker you're at the trauma center, the better chance you have of survival," a Las Vegas surgeon told NPR. The next closest trauma center is at least 5 hours away.
- "There is an unavailability of [medical liability] insurance," said Nevada State Insurance Commissioner Alice Molasky-Arman, at a March 4, 2002 hearing where insurance officials testified they would no longer insure any new obstetricians, surgeons and other high-risk specialists.

- A Las Vegas Ob-Gyn was forced to close her practice and leave 30 pregnant patients behind because her liability insurance increased from $37,000 to $150,000 in one year. She now practices in Los Angeles and pays only $17,000. Some Nevada women have had to call as many as 50 Ob-Gyns just to find one who is accepting new patients.
- Nevada ranks 5th among states with the highest physician liability premiums (at $94,820 per year), but only 47th out of 50 states in the number of physicians for its population, according to the American College of Obstetricians and Gynecologists. An ACOG survey concludes that 6 out of 10 Nevada Ob-Gyns will no longer practice obstetrics.
- "Approximately 100 Las Vegas physicians have already left Nevada to practice elsewhere, announced they will be closing their practices, or retire early because they cannot afford doubling, tripling, or quadrupling rates," according to the Nevada State Medical Association.
- In Las Vegas, it is expected that more than 10% of the physicians will stop practicing or relocate, further adding to the crisis in the state. *Los Angeles Times, March 4, 2002.*
- Recently, five trauma surgeons and 26 specialty surgeons made the difficult decision to resign or request leave from the University of Las Vegas Medical Center's trauma center. Some plan to leave June 30 and others July 31. This was expected to reduce by half the number of urologists, spinal surgeons, neurosurgeons, orthopedic surgeons, and cardiothoracic surgeons who could be on call to aid patients with life-threatening injuries. *Las Vegas Review-Journal, June 6, 2002.*
- Obstetricians and gynecologists remain particularly hard hit, who, like trauma centers, face premium increases of as much as 500 percent. *Las Vegas Review-Journal, March 6, 2002.*
- Earlier this summer President Bush spoke with Jill Barnes, a Nevada resident who is more than two months pregnant. Mrs. Barnes and her husband were recently told by their home physician that he would not be accepting any new obstetrics patients. Unable to find a Las Vegas-area obstetrician to treat her, Mrs. Barnes has been forced to go out of state to find one. "When she goes into labor, she'll have to drive across the desert for two hours" to Arizona, her husband told the Las Vegas Review-Journal. *The Washington Times, July 31, 2002.*
- Point in fact, Dr. Shelby Wilbourn, a Las Vegas-area obstetrician-gynecologist has cut staff, stopped taking new patients and decided to leave the state (he's going to Maine) after his insurance premium jumped from $33,000 to $80,000 this year. *The Washington Times, July 31, 2002.*

*New Jersey*

- A multi-physician practice in Teaneck, NJ, was forced to layoff employees and reduce the number of deliveries it performed because of medical liability insurance premium increases of more than 120 percent. "All of my colleagues are experiencing the same pressures," said George Ajjan, MD. *Bergen Record, May 22, 2002.*
- One out of every four hospitals—nearly 27 percent—has been forced to increase payments to find physicians to cover Emergency Departments. Physicians are increasingly reluctant to take on such assignments because of the greater liability exposure. Hospitals report that more and more physician specialties are being hit by the crisis. While a previous New Jersey Hospital Association survey in March 2002 found that OB/GYNs and surgeons were primarily affected, the new survey finds a deepening impact for neurologists/neurosurgeons, radiologists, orthopedists, general practitioners and emergency physicians. *New Jersey Hospital Association, Jan. 28, 2003 news release.*
- "We have as much to lose as they have," said Joan Hamilton, a patient who attended a recent rally in New Jersey in support of her physician. *Bergen Record, Oct. 6, 2002.*
- Physicians, nursing homes and hospitals are all in jeopardy. Liability premiums for hospitals increased more than 150% over the past 3 years. A N.J. American Hospital Association survey found that nearly 2/3 of hospitals had one or more instances where physicians were forced out of medicine because of high premiums.
- 64.8 percent of all New Jersey hospitals said they have had physicians stop practicing medicine or plan to stop because of the state's liability crisis.
- New Jersey's largest insurer, the MIIX company, declared May 9, 2002, it is getting out of the medical liability business. Previously, MIIX insured 7,000 physicians—nearly 40% of the state. MIIX previously left the medical liability insur-

ance markets in Ohio, Pennsylvania and Texas, citing those states' out-of-control legal climates as an unacceptable business risk.

- After years of only a few large jury awards, New Jersey had 26 greater than $1 million in 2001, and is averaging one a week in 2002, MIIX President Patricia Costante told the *Philadelphia Inquirer* June 4. New Jersey has no limits on non-economic damages in medical liability cases.
- New Jersey physicians are also facing difficulty finding new insurance because PHICO, which insured 9%, and St. Paul, with 6% of the market, have pulled out.
- After making the difficult decision to no longer deliver babies, one New Jersey obstetrician will see his liability insurance rates plummet from $82,000 to $8,000. "I'm devastated," one of patients told the *Atlantic City Press.*
- New Jersey physicians are predicting as many as 25% of the state's Ob-Gyns will be unable to afford liability insurance if nothing is done to stabilize the market. According to the Medical Society of New Jersey, premiums for Ob-Gyns have risen 50% to 200% over the past year.
- The New Jersey Supreme Court ruled May 29, 2002, that ER doctors are not immune from lawsuits under the state's good Samaritan law and may be sued for malpractice.
- Some general surgeons are seeing rate increases from $30,000 to $110,000. Zurich, one of the remaining liability insurance carriers has informed physicians it will raise rates 120 percent.

*New York*

- New York physicians still pay, in most instances, the highest medical liability premiums in the country. Ob-Gyns' average premium is $144,973, according to the American College of Obstetricians and Gynecologists.
- New York continues, by far, to lead the country in total medical liability payouts, with $633 million total in 2000. That is 80% more than the state with the second highest total, Pennsylvania (at $352 million), and 300% more than California (at $200 million). Average medical liability verdicts have skyrocketed recently, going from an average of $1.7 million in 1994 to $6 million in 1999.
- "The number of doctors leaving Erie County last year doubled from the previous year, a trend that continues in 2002," wrote Donald Copley, MD, an officer of the Erie County Medical Society in *Business First of Buffalo*. "I've watched sadly as valued colleagues have left Erie County and even the profession. A competent young specialist recently quit doing high risk diagnostic procedures to become a business consultant. Several local obstetricians have stopped delivering babies to reduce their insurance expenses. A half dozen nationally-known doctors have quietly left Western New York. The number of doctors leaving Erie County last year doubled from the previous year, a trend that continues in 2002." *Buffalo Business First, April 15, 2002.*
- The Medical Society of New York says the trend of physicians leaving New York State or retiring early is happening across the state.
- "The rising cost of malpractice coverage is becoming one of the most important factors driving inflation for physicians' services," said a managing director of the Carlyle Group, the investment group for *The New York Times.*

*Ohio*

- The Ohio Supreme Court has overturned three tort reform measures in the past 15 years. Following the state Supreme Court's 1995 overturning of the state's tort reforms, premium increases and jury verdicts began rising. Family physicians in rural areas are increasingly no longer performing obstetrical services. Recently, Ohio again enacted medical liability reforms, but it is too soon to tell if the courts there will let these reforms take root.
- Meanwhile, according to a recent Ohio State Medical Association survey, 79% of Ohio physicians reported an increase in their medical lawsuit insurance costs over the last two years, with an average increase of 41%. And 51% of Ohio physicians are contemplating early retirement, while 15% are considering or have relocated their practices, as a result of rising costs.
- Physician groups in Cincinnati are seeing increases between 20 and 100%. "I expect this to get worse," Ken Folz, CEO of Patient First, told the *Cincinnati Business Courier.*
- According to Daniel J. McLaughlin, a vascular surgeon in Cleveland, some specialists in the region have seen their malpractice premiums increase 600 percent this year, and typical premiums for surgeons with just three or four years of experi-

ence have doubled or tripled, to from $50,000 a year to as much as $100,000 or more. *Health Leaders Magazine, Sept. 2002.*

- In July, Westlake oncologist Dr. Romeo Diaz was faced with an insurance premium of $80,000—double what he paid last year. He would have gone out of business had it not been for his patients, who raised the needed $40,000 to help Diaz stay insured. "At first I thought he was playing," said Kathy Fritsch, a patient of Diaz for 10 years. "But when he looked up at me, he was crying. He said his insurance rose from $40,000 last year to $80,000 this year. It used to be $20,000." *Morning Journal, July 31, 2002.*
- Dr. William Hurd, chairman of the department of obstetrics and gynecology at the Wright State University School of Medicine, said the liability insurance issue already is driving young doctors out of the Dayton area. "In the last two years, not a single one of our (OB/GYN) residents has set up a practice in Dayton, or even Ohio," Hurd said. *Dayton Daily News, Aug. 28, 2002.*
- The average jury verdict in Ohio was $11.7 million in 2001. In 2000, it was $8.6 million.
- Physicians in Cleveland are being forced to lay-off staff and discontinue high-risk procedures, reported the Cleveland *Plain Dealer* February 18, 2002.
- After not replacing a retiring office manager and moving to a smaller office, a 55-year-old Cleveland-area surgeon who was only sued once quit practicing medicine rather than accept an 80% liability premium insurance increase. Another surgeon, who has never been sued, no longer performs high-risk procedures and saw his insurance rates jump from $40,000 to $90,000 in one year.
- "If I were advising medical students now, I would tell them to take a real hard look at going into some of these high-risk specialties," John Bastulli, MD, told the *Plain Dealer*.
- Ohio ranked among the top five states for premium increases according to the *Medical Liability Monitor.*
- "My premium jumped this year from $14,000 to $35,000. I can't afford to continue obstetrics at that price. I'll have to give up delivering babies as of Jan. 1, 2003. I practice in a primarily rural area, and there isn't any other obstetrical care here, so expectant women will have to drive long distances to receive prenatal care. Some 75% of my patients don't have the financial resources to do so. Yet, studies have shown that proper prenatal care fosters healthier newborns and healthier newborns cost society less money. I find it difficult to accept that my liability insurance premiums will force me to give up a side of my practice that has meant a lot to me and to my patients, but I'll have no recourse."—A Mt. Gilead family practitioner.
- "We've done the math: If we're going to take care of this debt (our annual insurance payment will increase from $100,000 to more than $500,000), our service is going to go out the window. To recoup the loss, we'd have to add 400 patient visits a month. You can't turn Ob-Gyn into a factory."—A Columbus obstetrician-gynecologist.
- "I just sat down with paper and pencil, and it became not financially rewarding to stay."—An Athens obstetrician-gynecologist, in reference to why he retired from his practice early.
- "I practice in southern Ohio in a town of 7,000. We have a small community hospital with a family birth center. There are three of us who do obstetrics—two family practitioners and one OB/GYN. In order to break even, our unit needs 150 deliveries a year. That is 50 deliveries each. If we go over 30 deliveries now, our premiums are in the $40–60,000 range, which is impossible financially. We are struggling with limiting our ob to 30 each, but that will cause the OB unit to go under and close. We all love ob, and are well trained in providing high-risk OB care, but we're going to be forced to stop. If this occurs, there will be no OB care between Athens and Lancaster, Ohio. Tort reform needs to occur yesterday!"—A Logan family practitioner
- "I'm just postponing the inevitable. If the situation doesn't change, I could be insolvent in five years and have to close my practice. I'm only 49. Who will care for my patients? Discontinuing obstetrics is not an option. We need help!"—A Dayton obstetrician
- "In the past two years, my medical liability premiums have increased more than 50%. I have no claims, graduated first in my medical school class, and was chief resident at OSU. I had been treating some of my chronic pain patients with acupuncture (medical research documents decreased pain and decreased inflammation with acupuncture). Due to the skyrocketing medical liability premiums, I will

have to stop offering this treatment for these patients to try to decrease my costs of insurance."—A Columbus physical medicine and rehabilitation physician.

- "My premiums increased significantly, but my reimbursement level is down because of the Medicare cuts. In order to stay in practice, I had to float a loan from my pension fund. I am actively looking to leave this state. I know of one colleague who gave up his private practice and went to work at the local VA hospital, so they would cover his liability premium.—A Warren cardiologist.
- "This five physician practice recently had to give up obstetrics due to our rates. We have been committed to delivering full-range family practice...true womb to tomb medicine. We had to send our patients to local OBs. We and our patients are devastated by this turn of events."—A Medina family practitioner
- "After a mad scramble to obtain insurance, it came down to 5:45 p.m. on the day before my insurance expired to obtain insurance. I was literally 15 minutes from having to close a practice that cares for over 4,000 people in this town."—A Coldwater family practitioner
- "We have an obstetrician-gynecologist retiring because his insurance company pulled out of Ohio. To buy a tail and the new policy would cost this man $140,000, which he couldn't afford to do."—A Rossford obstetrician-gynecologist.
- "I was told two months ago that I will have no insurance after the 11th of September. I have had no claims filed against me."—An Akron general surgeon
- "My carrier has refused to cover me for bariatric procedures. I have had to turn patients away who need this service."—A Massilon general surgeon

*Oregon*

- Rural families in John Day, Hermiston, and Roseburg counties, Oregon have either lost obstetric care or have seen services drastically reduced. *The Business Journal of Portland, Jan. 10, 2003.*
- Only by dropping obstetrics were two Hermiston physicians able to afford their liability insurance premiums. "It's something you don't like to tell patients," said Doug Flaiz, MD. *The Oregonian, Oct. 29, 2002.*
- "No one with $100,000 in debt from medical school wants to start a practice in a place where they could find themselves completely broke and having to pick up and go somewhere else to start all over again," said Rosemari Davis, CEO of Willamette Valley Medical Center, who has seen three of her center's family practitioners stop delivering babies. *The News Register, Jan. 28, 2003.*
- In 1999, the Oregon Supreme Court overturned the State's law capping non-economic damages. Since then, multi-million dollar claims have become commonplace, according to the Oregon Medical Association.
- Since the 1999 decision, Oregon physicians are experiencing rapidly rising premiums and insurers becoming more reluctant to offer policies to physicians, such as Ob-Gyns and surgeons, who perform high-risk procedures.
- Recent jury verdicts include: $8 million, $8.5 million, $10 million and $17 million.
- Rural patients in Oregon are being particularly hard hit. A small town clinic, Roseburg Women's Healthcare, which delivered 80% of the babies for the area, closed its doors in May 2002 because its liability insurance was canceled after one large lawsuit. "We consider this a medical crisis for the community," Mercy Medical CEO Vic Fresolone told the Associated Press.
- The Roseburg clinic physicians paid $17,000 per physician per year in 2001 for medical liability insurance and are now receiving quotes for $80,000–100,000 per physician.
- Oregon's only academic health center—the Oregon Health & Science Center—reports fewer medical students are applying for its Ob-Gyn residency positions. Ob-Gyn residents elsewhere reportedly are increasingly concerned about setting up practice in Oregon due to the state's broken liability system.
- A major liability insurer, Northwest Physicians Mutual Insurance Company, announced in 2002 it would not write new policies to obstetricians. Remaining insurers are raising rates by 60% or more.
- "We lost $12.5 million last year (2001)," Jim Dorigan, CEO of Northwest Physicians Mutual, told the Portland Business Journal June 21st. Dorigan also said the company no longer is renewing policies for any physician who delivers babies.
- A level-III trauma center in Rogue Valley is dropping its trauma designation to obtain professional liability insurance. Rates would have been unaffordable if neurosurgery continued to be performed.

*Pennsylvania*

- According to the Pennsylvania Medical Society Alliance, 919 doctors have decided to leave the Keystone State or have scaled back their practices as premiums spiraled upward over the past three years. *The Baltimore Sun, Feb. 5, 2003.*
- Dr. Anthony Clay never thought he would have to leave Philadelphia. He has spent his whole life there—growing up and attending college, medical school, and residency to become a cardiologist. He treats families he has known since boyhood. He likes knowing where his patients live, work, and shop. All nine of his siblings still live there. But, Dr. Clay is leaving his practice in Philadelphia this Spring because of surging malpractice insurance rates. He is starting over in Delaware, where his insurance costs will drop from roughly $70,000 a year to $8,000. "It's been terrible," said Dr. Clay, 40. "In this field, you've been with the patient, and also the family, in some of their most life-defining moments—in the throes of a heart attack with no blood pressure. Wrongly or rightly, the patient credits you with being there when they weren't doing so well. You realize you've created a bond. I take that very seriously." *Baltimore Sun, February 5, 2003.*
- Brian Holmes, MD, is one of an estimated 18 percent of Pennsylvania neurosurgeons to have left the state, retired, or limited his or her practices because of the medical liability crisis. "It saddened me to move, but I had no choice. It was either move or go out of business." *Philadelphia Business Journal, Sept. 25, 2002.*
- After 25 years of practice, OB/GYN Michael Horn, MD, stopped delivering babies in 2002 because of the fear of getting sued. "It's just the potential, the not knowing if someone will seek an outlandish reward. I don't want to expose myself or my family." *Burlington County Times, Oct. 2, 2002.*
- Medical students are less likely to seek residencies in Philadelphia, and residents are less likely to stay and practice in the area because of "prohibitively high" medical liability insurance rates, according to Jefferson Medical College professor Stephen L. Schwartz, MD. *Associated Press, Oct. 4, 2002.*
- OB/GYN Lawrence Glad, MD, used to deliver about 500 babies a year—40 percent of all the babies born in Fayette County annually. After his premiums skyrocketed from $57,000 to $135,000, however, he closed his practice in the fall of 2002. *Pittsburgh Business Times, Nov. 18, 2002.*
- Mercy Hospital chief of surgery Charles Bannon, MD, has watched numerous physicians leave Scranton and Lackawanna County—creating a shortage of surgeons, fewer medical school applications and residencies. "It will take generations to get back the quality of medicine in Philadelphia." *Scranton Times, Nov. 20, 2002.*
- Physicians across the "Keystone State" have left, retired, and stopped performing high-risk procedures. Those who have stayed face skyrocketing premiums, extremely nasty legal climate. Methodist Hospital in South Philadelphia closed its maternity ward and prenatal program last year because of unaffordable medical liability insurance rates. Mercy Hospital of (South) Philadelphia announced June 19, 2002 it would closed its ob ward August 23rd.
- Pennsylvania has the second highest payouts in the country for medical liability lawsuits. Pennsylvania's total in 2000 was $352,309,905—nearly 10 percent of the national total despite having less than five percent of the national population.
- Orthopedic surgeons in Pennsylvania face insurance premiums of nearly $100,000. In California, which has strong tort reforms, orthopedic surgeons pay an average of $36,310 for yearly liability insurance coverage.
- A recent poll, conducted by Susquehanna Polling Research, shows that 31 percent of doctors participating in the study had their existing liability insurance cancelled or non-renewed for 2002.
- 72% of Pennsylvania doctors have deferred the purchase of new equipment or hiring of new staff because of out-of-control liability costs.
- 270 employees at the Jefferson Health System in Philadelphia have recently lost their jobs to skyrocketing liability insurance costs. The Einstein Network laid-off 127 workers and eliminated 52 vacant positions in April 2002, citing rising liability costs as the prime factor.
- Philadelphia County, which has one of the worst liability climates in the nation, has seen its surgical specialist population decrease 13.4% from 1995 to 1999. The average jury award in Philadelphia County is $970,000 while the rest of state's average is $420,000.
- A shortage of radiologists willing to read mammograms has increased the wait time for screening mammograms at most major hospitals to two to three months,

according to the Pennsylvania patient advocacy group Concerned Citizens for Care.

- The Level-II trauma center at Brandywine Hospital in Coatesville closed June 10th, because of rising malpractice insurance rates. Area trauma patients are now being transported more than 30 miles away to hospitals in Philadelphia and Lancaster. *The Washington Times, July 17, 2002.*
- "As I look around and see my friends retiring early or leaving Pennsylvania, I wonder who will be next," Meadville physician Tom Arno, MD, wrote in *USA Today.*
- 414 medical liability lawsuits were filed in Philadelphia County in February 2002—five times the average number filed during the month over the previous decade, reported the *Philadelphia Inquirer.*
- One-quarter of respondents to an informal poll conducted by the American College of Obstetricians and Gynecologists say they have stopped or are planning to stop practicing obstetrics.
- Statistics compiled for the Pennsylvania Medical Association by Caso Consulting indicate it costs $96,199 to cover an orthopedic surgeon in Pennsylvania, compared with $37,783 in Delaware, and $36,291 in New Jersey. *Best's Insurance News, January 7, 2002.*
- Howard A. Richter, a neurosurgeon and president of the Pennsylvania Medical Society, said a 2001 survey by the medical society showed that 72% of doctors have either deferred the purchase of new medical equipment or have not hired needed staff because of "sudden and sharp increases" in insurance rates. *Best's Insurance News, January 21, 2002.*
- "To lower their risk and insurance premiums, doctors who normally would take on high-risk medical procedures are opting not to do so. For example, we've seen obstetrician/gynecologists give up delivering babies. Virtually every medical liability insurance carrier increased their rates in recent years. From the beginning of 1997 through September 2001, major liability insurance carriers writing in Pennsylvania increased their overall rates between 80.7 percent and 147.8 percent." *York Daily Record, January 20, 2002.*
- Driving premiums through the roof are excessive sums awarded in malpractice suits. Medical liability payments for physicians in 2000 totaled $3,908,113,303. *York Daily Record, January 20, 2002.*

*Texas*

- In the "Lone Star State" medical liability insurance premiums for physicians have skyrocketed as much as 300 percent in some regions and for some specialties, acccording to the Texas Medical Association. As a result, there is only one neurosurgeon serving 600,000 people in the McAllen area.
- In the past two years, four South Texas patients with head injuries died before they could be flown out of the area for medical attention. As reported in a July 10, 2002, article in The Courier, a community family practice clinic in Conroe (just north of Houston) was recently forced to turn away half of its normal patient load because its liability insurance provider would not provide coverage while "highly lawsuit-risky obstetrics training was conducted."
- Even though the Texas legislature has passed medical liability reforms, the Texas Supreme Court has regularly overturned them.
- Medical liability premiums were expected to increase by at least 20 percent and perhaps as much as 75 percent in 2002, according to the Texas Department of Insurance. *San Antonio Express-News, April 8, 2002.*
- In 1999, 17 companies offered malpractice coverage to doctors in Texas. Today, the field has dwindled to only four, and Texas is considered the least profitable state for liability carriers. *The Dallas Morning News, September 1, 2002.*
- Moreover, premiums this year have climbed at triple-digit rates for many of Texas' 36,000 physicians. That's on top of double-digit increases in prior years. Now it's not uncommon for doctors in high-risk specialties such as trauma surgery, emergency medicine, and orthopedic surgeries and obstetrics to pay more than $ 100,000 annually for coverage. This means that some 6,100 Texas physicians are scrambling to find liability insurance.
- The Doctor's Company, a national insurer, told the *Dallas Morning News* the company is selective about which types of physicians it will cover. "Texas is a very dangerous venue, and we don't really encourage . . . [growth] from there—not without tort reform," said senior vice president Jack Myer.

- In South Texas, one jury awarded $43 million to a woman who claimed a diabetes drug damaged her liver, while another gave $15 million to three women who received faulty hip implants. *The Wall Street Journal, May 1, 2002.*
- 6 of every 7 medical liability claims in Texas are closed with no fault found on the doctor's part. Nonetheless, tens of millions of dollars are spent fighting these cases.
- Family physician Marissa Iniga, MD, has been sued 12 times in the past 13 years. All of the lawsuits were dropped but her insurance premiums still went up 200 percent. Her situation is mirrored by many physicians throughout Texas.
- Several physicians in Corpus Christi have been sued by patients they have never seen, but it required thousands of dollars to have the cases dismissed.
- Currently obstetrician/gynecologists in Cameron, El Paso and Hidalgo Counties are paying one carrier a premium of $102,584 annually compared to their counterparts in Dallas County who pay $59,221. Another carrier charges thoracic surgeons in Cameron, El Paso and Hidalgo Counties $79,218 annually compared to $57,395 for those practicing in Dallas County.
- 70% of Texas physicians who practice near the U.S.-Mexico border have had medical liability claims filed against them, and 60% have been sued, according to the Texas Medical Association. 55% of physicians there are inclined to leave the border and practice elsewhere or retire during the next 12 months; 71% to 76% of border doctors say they cannot recruit new doctors to the border due to lawsuit crisis, and 1 out of 3 border physicians have had insurance carriers decide to stop writing coverage.
- The high cost of malpractice insurance for local doctors is driving them away from Laredo. The three main issues for this exodus are the high price of malpractice insurance for border area physicians, tort reform and the fact that Medicaid and Medicare do not reimburse border area physicians proportionate to what they do farther north, director of Community education/Physician Relations Mindy Casso said. *Laredo [Texas] Morning Times.*
- The second-highest premiums for obstetricians/gynecologists are paid in Houston, Dallas and Galveston, Texas, where the bills amounts to some $160,746 a year. *Orlando Sentinel, January 20, 2002.*
- "Dr. William F. Tucker, an orthopedic surgeon, figured he'd try to curb the cost of his malpractice insurance premium by abandoning spinal surgeries and reducing his emergency room calls. Both decisions cut down on his income but provided him with a greater sense of security as malpractice lawsuits against doctors become more common in Texas and the nation. Then came the shocking news that his premium would rise by 63 percent to $38,000." *The Dallas Morning News, January 20, 2002.*
- The problem is particularly acute in Texas, where 51.7 percent of all physicians in 2000 had claims filed against them, according to the Texas Medical Examiners Board. Although no concrete numbers are available as a comparison, several industry experts say the frequency is twice the national average. *The Dallas Morning News, January 20, 2002.*
- In Texas, about 85 percent of cases are closed without payment to plaintiff, yet they still cost money to resolve, said Texas Medical Liability Trust president W. Thomas Cotton. *The Dallas Morning News, January 20, 2002.*
- Insurance carriers in Texas paid more than $381 million in claims in 2000, according to the Texas Department of Insurance—costs passed on to policyholders. That's an 87 percent increase since 1995. Nationally, the median malpractice award more than doubled from 1994 to 1999, to $800,000. *The Dallas Morning News, January 20, 2002.*
- Texans filed 4,501 claims in 2000, up 51 percent from 1990, according to the Texas Medical Examiners Board. More troublesome is the rise in expenses involved in resolving a case. Each claim cost an average of $68,681 to litigate in 2000, compared with $46,079 in 1995. The figure does not include the amount of settlement or award. *The Dallas Morning News, January 20, 2002.*
- Meanwhile, physicians in the Rio Grande Valley are in crisis, said Texas Medical Liability Trust president W. Thomas Cotton. An Ob-Gyn in North Texas pays $47,500 annually for $500,000 in coverage, while his Rio Grande Valley counterparts pay $82,300. Neurosurgeons pay even higher premiums. *The Dallas Morning News, January 20, 2002.*
- Seven in 10 Rio Grande Valley doctors have had medical liability claims filed against them. A February 2001 survey by the Texas Medical Association found

that 1 in 3 Valley doctors say their insurance providers have stopped writing liability insurance. *The Dallas Morning News, January 20, 2002.*

- In Rio Grande Valley, half of the physicians admitted to being inclined to leave the area or to retire, according to a survey conducted in February 2001 by the Texas Medical Association. Many doctors in the Valley said they profile patients and refuse to treat some, because they fear the patients are prone to sue. They said they deny care for people who pay with cash, because the patients are most likely poor and may look at a lawsuit like a lottery opportunity. Some physicians are even hesitant to respond to a "code blue," which indicates a medical crisis, in a hospital. Dr. Carlos Cardinez, a gastroenterologist in McAllen, said he doesn't want to respond anymore because of the legal uncertainty. *The Dallas Morning News, January 20, 2002.*
- Increases in medical practice costs have outstripped revenue increases over the last 10 years, according to the Medical Group Management Association's 2000 cost survey. Operating costs for multispecialty groups went up an average of 35 percent over the past 10 years, while revenue increased 21 percent over that same period. *The Dallas Morning News, January 20, 2002.*

*Washington*

- "There is a growing crisis in medical malpractice in Washington state and nationally," state insurance commissioner Mike Kriedler said in an April 2002 news release.
- 'Patients in many communities are finding that their physicians have either started limiting their services or have closed their doors completely due to rising malpractice premiums," said Dr. Maureen Callaghan, president of the Washington State Medical Association. *PR Newswire, Feb. 3, 2003.*
- "I went through my mourning and my grieving, and now I have to find a place for my [380] patients," said a South Send internist who has not been sued but can no longer afford liability insurance coverage.
- The cost of medical malpractice insurance has soared so high that Mount Vernon obstetrician Robert Pringle, MD, has stopped delivering babies, according to the *Puget Sound Business Journal.*
- So have his two colleagues at the North Cascade Women's Clinic, and so have others. "Of the nine obstetricians in our community, six have stopped delivering babies or left the area," Pringle said.
- When he began his practice 20 years ago, Pringle paid a premium of $1,000 for medical malpractice insurance, which covers physicians against claims of injury resulting from negligent medical care. "Now it's in the neighborhood of $60,000," he said. "From an economic standpoint, you would have to be a lunatic to continue private practice of obstetrics." *Puget Sound Business Journal.*
- The severe premium hikes besetting many doctors "could not come at a worse time," said Dr. Sam Cullison, president of the Washington State Medical Association. Cullison said the high cost of malpractice insurance has combined with low reimbursement rates from Medicaid, Medicare and private insurers to clamp many doctors in a financial squeeze. As a result more physicians are retiring early, or leaving the State, he said. Also, it's increasingly difficult to recruit doctors from other states." *Puget Sound Business Journal.*
- "Everyone is in the same situation in terms of increasing premiums, increasing overhead and decreasing reimbursement," said Olympia neurologist Maureen Callaghan, MD. "The final end point," she added, "is that people are not to be able to get in to see a doctor." *Puget Sound Business Journal.*
- During the past five years, medical liability premiums paid by orthopedic surgeons increased 30 percent, to nearly $40,000, and premiums paid by family physicians who neither deliver babies nor do surgery rose 29 percent, to almost $10,000. *Washington State Medical Association.*
- In Washington, from 1999 to 2000, the median jury award rose 43 percent. Last year, seven medical malpractice verdicts or settlements exceeded $1 million. They totaled $44.7 million, and ranged from $1.2 million to $16.2 million.
- Washington's Supreme Court overturned the state's tort reform law in 1989. As a result skyrocketing medical liability insurance premiums are forcing physicians to limit patient loads and services. Some physicians are choosing to move out of State and retire early as well.
- In the past five years, the average medical liability premium for a family physician has increased a staggering 74 percent, according to the Washington State

Medical Association. For obstetricians, the increase has been more alarming—79 percent since 1997.

- The departure of liability insurers St. Paul and Washington Casualty Company from Washington have left thousands of physicians scrambling to find coverage.
- The Steck Medical Group, which serves 60,000 patients in mostly rural Washington, was forced to close its doors for a few days this year because it could not find liability insurance coverage. It re-opened only after the state insurance commissioner intervened, but the new policy was at a 160% increase.
- Clinics in Lewis County and Waterville also have been forced to close temporarily according to *The Olympian.*
- Recent large jury awards in Washington State include $13 million and $16 million verdicts.

*West Virginia*

- The "Mountaineer State" was one of the first states to experience wide-spread medical liability insurance problems.
- According to the West Virginia State Medical Association, some 100 doctors have already retired early or moved out of the state within the previous two years.
- That has helped drive 1 out of every 20 doctors out of West Virginia or into early retirement in the past two years. *CNN, Jan. 2, 2003.*
- General surgeon Gregory Saracco, MD, only 49 years old, was forced to borrow money twice in 2002 to pay $73,000 for his liability insurance. His premiums for 2003 are expected to rise to $100,000. He is considering leaving West Virginia and while he has taken time away from his practice this year to decide what his options are, he said "my job is to help people—I couldn't drive past an accident on the road and not stop. I don't know any doctor that could." *Associated Press, Jan. 2, 2003.*
- Although orthopedic surgeon George Zakaib, MD, was raised and went to school in Charleston, WV, he and his family left because of the state's medical liability crisis. Dr. Zakaib's premiums had increased to $80,000 plus $94,000 in "tail" coverage. *Charleston Daily Mail, July 27, 2002.*
- Fourth-year medical school student Jennifer Knight isn't sure she'll stay in West Virginia. The Charleston Area Medical Center says fewer medical students are applying to its residency programs, and fewer students are applying to Marshall University's medical school. "I think the problem is, we have too many frivolous lawsuits," said Ms. Knight. *Sunday Gazette-Mail, Nov. 24, 2002.*
- The state legislature has been trying for more than a year to come up with a solution that will prevent more physicians from curtailing services or leaving the state. A state medical association poll found that 40% of the State's doctors are considering similar action to stop practicing or leave the State.
- "It's a 'code blue' emergency" threatening the state's trauma centers and other health care services in the state, WVSMA President Ahmed D. Faheen, MD, told *The New York Times.*
- Wheeling, West Virginia, has no remaining neurosurgeons, forcing closure of its only trauma center. Trauma patients must be flown by helicopter for care elsewhere.
- Across the State, the pattern is the same, trauma centers are closing or headed in that direction, and there is incredible difficulty in recruiting high-risk specialty residents.
- Earlier this year, in the State Capital, the Charleston Area Medical Center (CAMC) was able to keep its level-I trauma center open only after agreeing to help surgeons pay their liability premiums. The one part-time and three full-time surgeons are paying $800,000 in liability premiums this year, according to a report in the April 25, 2002 *Charleston Gazette.*
- Now, after the loss of several orthopedic surgeons, CAMC can no longer offer 24-hour coverage seven days a week. That means patients with serious multiple injuries, usually car wreck victims, must be transported to other cities. Precious time that could mean the difference between life and death will be lost. *The Charleston Daily Mail, August 29, 2002.*
- The Medical Liability Monitor reported that West Virginia surgeons paid premiums of $36,094 to $56,371 a year in 2001—the seventh highest in the nation. This year these premiums have continued climbing dramatically. *The Charleston Daily Mail, August 29, 2002.*

- As the *The New York Times has reported, the Bluefield Regional Center—a rural hospital—has lost 12 physicians in the previous two years but only has been able to find two physicians to replace them.*
- A survey of state Ob-Gyn residents by the American College of Obstetricians and Gynecologists found more than half plan to leave when they finish training.
- Without action, the future is not bright. The Charleston hospital faces an 11%–41% drop in residency applications this year. "We are concerned that students will not think the residency opportunities in West Virginia favorable in light of the recent problems with malpractice insurance," Dean James Griffith, MD, told the *Charleston Gazette.*

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## APPENDIX C

### MEDICAL LIABILITY CRISIS AFFECTS ACCESS TO CARE

### SELECTED STATES SHOWING PROBLEM SIGNS

#### THE MEDICAL LIABILITY CRISIS—A NATIONWIDE PROBLEM

*Alabama*

- The severe liability crisis in the neighboring States of Mississippi, Georgia and Florida has not left Alabama untouched.
- Atmore Community Hospital has had to close its maternity ward because of soaring medical liability premiums, forcing pregnant mothers to travel 15 miles to the nearest hospital with an obstetrics department.

*Arizona*

- Arizona has not been immune to the medical liability crisis. Serious access problems are already developing.
- The Copper Queen Community Hospital, was forced to stop delivering babies in January after a group of family physicians said they could no longer afford medical liability insurance.
- Pregnant mothers in this part of Arizona must now travel over 35 miles to the nearest hospital—the only hospital left in that County that is still delivering babies.

*Connecticut*

- The crisis may be spreading to Connecticut as evidenced by the recent decisions of 28 OB/GYNs to stop delivering babies.
- Some OB/GYNs in Connecticut are now paying between $120,000–160,000 per year in insurance premiums, according to state medical society executive Tim Norbeck.
- Connecticut already is on a "watch" list issued by the American College of Obstetricians and Gynecologists. *Hartford Courant, Jan. 3, 2003.*
- The average payment made by one of Connecticut's major insurers to resolve a claim rose from $271,000 in 1995 to $536,000 in 2001.
- OB/GYN Jose Pacheco, MD's, insurer stopped offering medical liability insurance, and he had to seek another carrier. However, because of the high cost of new insurance—estimated around $60,000—combined with "tail" coverage of $80,000, Dr. Pacheco retired after a 27-year career. *Hartford Courant, Nov. 17, 2002.*

*Kentucky*

- Health care access problems will worsen in the "Blue Grass State," as medical liability premiums continue moving rapidly upward.
- Based on a survey by the Kentucky Medical Association, physicians in Kentucky have faced a recent average increase in medical liability premiums of 78 percent.
- Kentucky emergency department physicians have reported an average increase of 204 percent, with orthopedists facing a 122 percent increase; general surgeons facing an 87-percent average increase, and Ob-Gyns seeing an average increase of 64 percent.
- Deep in Appalachia, the only provider of obstetrical services in Barbourville soon may have to close its practice due to the liability crisis. Previously, this physician group had liability insurance coverage through St. Paul Company, the nations second largest malpractice insurer that pulled out of the market last year.

- This same 9-physician practice also has an office in Corbin, where two resident physicians from the University of Kentucky College of Medicine train in conjunction with Baptist Regional Medical Center. If the physicians are forced to close the practice, the residents will have to be placed out of State for the remainder of their training. leaving a tremendous access problem for the Kentucky women they treat.

*Massachusetts*

- In the Bay State, eight of 55 OB/GYNs in Springfield, Massachusetts, a state which has broad exceptions to the state limits on non-economic damages, will no longer be offering Obstetrics care to their patients because of sharply escalating liability insurance costs. "I got into obstetrics because it's a very happy specialty. But there comes a point where you can't make ends meet," said James Wong, MD, one of two OB/GYNs at a western Massachusetts clinic giving up delivering babies. *Boston Globe, Jan. 8, 2003.*
- "The real issue is runaway juries," according to Barry Manual, MD, who serves as insurer ProMutual's chairman, and said the number of $1 million-plus claims paid out doubled between 1990 and 2001. *Boston Globe, Jan. 8, 2003.*

*Missouri*

- The State of Missouri is starting the slide into a full-blown medical liability crisis.
- Missouri Ob-Gyns are routinely seeing premium increases of 200–300 percent and even upwards of 1,000 percent in some cases, forcing some physicians to close part or all of their practice.
- A recent survey completed by the Missouri State Medical Association found that 31.4 percent of the responding physicians were considering leaving their practice, and 28.6 percent said they would consider limiting their practice because of rising liability insurance premiums.
- This same survey showed an average premium increase for medical liability insurance of 61.2 percent for 2002, on top of a 22.4 percent average increase last year.
- Neurosurgeons in Kansas City are facing an increase in premiums of $12,000 to $42,000 this year, with further increases expected next year.
- The 2002 premiums for Ob-Gyns have increased by as much as $50,000 from 2001. Again, further increases are expected next year.
- According to a separate survey by the Metropolitan Medical Society of Greater Kansas City, 40% of practices are looking for new coverage because their insurer has stopped writing medical liability coverage.
- Predictably, an access crisis to needed health care is developing. The St. Joseph Health Center in Kansas City recently lost another trauma doctor. It is now down to three. The situation is even worse because a local nearby trauma center has been virtually shut down, meaning St.Joseph's must treat double the number of patients, and it is having trouble finding other surgeons willing to cover trauma.
- According to the *St. Louis Business Journal*, access issues are spreading. Dr. John Anstey, an obstetrician/gynecologist, recently faced a difficult choice. He knew he had to cut expenses after learning his medical malpractice insurance premium, which cost about $26,000 this year, would jump to $50,000 next year. Consequently, he closed his office in St. Ann effective July 30th. Previously, Anstey and his partner, Dr. Fred Monterubio, Jr., deliver about 400 babies a year through their practice, St. Ann OB/GYN. As a stopgap measure, Drs. Anstey and Monterubio were forced to move their practice to a hospital-based setting where they await news of their 2003 premium by October.
- The current medical liability insurance market in Missouri is extremely tight, with at least three insurers having pulled out of the market over the past year.
- Intermed Insurance Company, based in Springfield, is the largest provider of medical liability insurance coverage in Missouri. The Missouri Department of Insurance said the company had a 34 percent market share in 2001. The company imposed an 18 percent hike, effective July 1, and also put a moratorium on writing new business in Missouri.
- Andy Bennett, president and chief executive of Intermed, said rates went up because the severity, or average amount paid per settlement or verdict, has continued to go up fairly dramatically in Missouri. *St. Louis Business Journal.*

*North Carolina*

- The "Tar Heel" state is on the verge of lapsing into a full-scale medical liability crisis that could seriously endanger access to needed health care.

- Hospitals in the Charlotte area are currently facing liability insurance premium increases of up to 400% this year.
- Dr. Harold Pollard, a physician with Lyndhurst Gynecological Associates, said "North Carolina is on its way to being one of those crisis states." Dr. Pollard has said that liability costs are creating a shortage of necessary health care services. "What that results in is a lack of good obstetricians. We have counties in this State that have no obstetricians."
- Recently, Dr. John Schmitt, an Ob-Gyn whose insurance premiums tripled from $17,000 to $46,000, causing him to give up his practice to join the medical school faculty at the University of Virginia. Former patient Laurie Peel said, "he was a great doctor. When you are a woman, you try to find a gynecologist who will take you through lots of things in life. I suffered a miscarriage. You develop a relationship with your doctor. To lose someone like that is very hard." *Charlotte Observer, Jul. 25, 2002.*
- According to the North Carolina State Administrative Office of the Courts, the number of medical malpractice lawsuits filed has increased 18 percent in the past five years.
- A greater number of medical malpractice lawsuits are ending in multi-million jury awards or settlements across North Carolina. In 2001, 21 lawsuits in North Carolina resulted in multi-million awards or settlements. According to N.C. Lawyers Weekly, the top five recoveries ranged from $4.5 million to $15 million.
- Facing a 660% increase in medical liability premiums from $53,000 to $350,000 a year, a practicing physician who runs a chain of six North Carolina urgent care clinics fears that soon he will have to stop practicing medicine and close his clinics' doors. He needs liability coverage for both himself and nine other physicians employed by the clinics. For this year, the insurer agreed to renew at a 79 percent increase, allowing the clinics to stay open for now. Increases like this will make staying in business and treating patients very difficult if not unsustainable.

*Oklahoma*

- Oklahoma physicians are beginning to face problems in obtaining affordable medical liability coverage. *The Oklahoman, July 17, 2002*
- According to *The Tulsa World*, that makes Oklahoma one of 30 states with a problem in this area.
- The World cites the example of a Tulsa pediatrician whose malpractice insurance doubled this year. *The Oklahoman, July 17, 2002*
- Oklahoma pediatricians have far less to worry about than the State's obstetricians and surgeons, whose rates in Oklahoma in 2003are expected to rise by 25 percent to 30 percent, says the Oklahoma State Medical Association.

*South Carolina*

- The medical liability crisis is rapidly spreading to the Palmetto State.
- A 10-physician OB/GYN group in Columbia had to take out a $400,000 loan this year to continue to provide OB services *and* pay malpractice premiums.
- In rural Oconee County, just four physicians deliver babies now, down from 11 physicians one year ago.
- A family practice group in Seneca was forced to drop OB coverage for four of their six physicians because of skyrocketing premiums. There are currently a total of four physicians in Seneca treating pregnant women.
- A solo practitioner practicing geriatrics in Charleston has had to quit treating patients in nursing homes because of high premiums.

*Tennessee*

- Professional liability premiums for physicians in Tennessee have been steadily rising in recent years.
- According to State Volunteer Mutual Insurance Company, which covers most practitioners in Tennessee, premiums have increased by 45% over the past three years, in order to keep up with rapidly escalating losses in medical liability lawsuits.
- Only approximately 4% of this 45% increase was related to lower investment yield, with the remainder being due to increasing medical malpractice losses. (State Volunteer Mutual Insurance Company is a policyholder owned mutual company with no outside investors).

- In recent years both juries and judges in Tennessee have made multi-million dollar awards for non-economic damages, over and above a patient's actual economic losses.
- In one recent case, a jury awarded only $25,000 in economic damages but awarded non-economic damages of $1.6 million.
- Another case resulted in a jury award of $100,000 economic loss and $1.9 non-economic damages.
- A judge in another cases awarded $1,062,080 in economic loss and gave $4.5 million in non-economic damages. Yet another court awarded $687,691 in economic loss and gave $3 million in non-economic damages. One other jury awarded $7,811 in economic loss and a staggering $2.65 billion in non-economic damages.
- Award in PI and wrongful death cases are dramatically increasing. Tennessee's Administrative Office of the Courts reported that in FY 2001, even though fewer cases were disposed of in Tennessee than in the previous fiscal year, damages awarded statewide were more than $94 million, representing an increase of more than $51 million over the previous year. These totals were the largest since the courts began reporting these statistics.
- According to the same report, the average award for FY01 was $209,284 up $95,064 from the previous year.

*Vermont*

- The current medical liability insurance crisis continue to show that events in one State can have a devastating effect and cause severe problems elsewhere.
- The failure of medical liability insurer, PHICO, which was shut down by the Pennsylvania Insurance Department on February 1 of this year, left more than a quarter of Vermont's physicians scrambling for medical liability insurance.
- Whenever medical liability insurance becomes too expensive or difficult to obtain, access to needed health care is threatened and typically results.

*Virginia*

- Physicians in Virginia are starting to see the warning signs of a full-blown medical liability crisis that has engulfed their neighbors to the north in West Virginia, Pennsylvania and other States. The telltale sign is a sharp upswing in liability premiums. Over the past two years physician premiums have increased on average over 30 percent.
- For some specialists, medical liability premiums in Virginia have increased upwards of 60 percent for this same recent two-year period.
- A case in point is Manuel Belandres, MD, a general surgeon who was is in the twilight of his career but still practicing until recently when he was unable to obtain tail coverage. He subsequently closed his practice rather than expose himself to open-ended future liability.
- In Virginia's western border, many physicians are no longer treating West Virginia patients who cross the State-line due to aggressive personal injury attorneys attempting to bring suit against Virginia physician in West Virginia courts. This has further aggravated the access problem for pregnant West Virginia Medicaid patients, in particular, and their access to needed care.

Mr. SMITH. Mr. Smarr.

## STATEMENT OF LAWRENCE E. SMARR, PRESIDENT, PHYSICIAN INSURERS ASSOCIATION OF AMERICA

Mr. SMARR. Thank you, Mr. Chairman. I am Larry Smarr, president of the Physician Insurers Association of America. The PIAA is an association comprised of professional liability insurance companies owned and/or operated by physicians, dentists, hospitals and other health care providers.

The PIAA members can be characterized as health care professionals caring for the professional liability risks of their colleagues; doctors insuring doctors, hospitals insuring hospitals. But we believe that the physician-owned/operated insurance company members—that PIAA insures over 60 percent of America's doctors.

Over the past 3 years, medical liability insurers have seen their financial performance deteriorate substantially, due to the rapidly rising costs of medical liability claims. According to A.M. Best, the leading insurance industry rating agency, the medical liability insurance industry incurred $1.53 in losses for every dollar of premium it collected in 2001. The industry data for 2002 is not yet available, but we expect this to be a losing year as well.

The primary driver of the deterioration in the medical malpractice insurance performance has been paid claims severity, or the average cost of a paid claim. This has been confirmed by the president of the National Association of Insurance Commissioners in his February 7, 2003, letter to Senator Gregg, which is attached to my written testimony. Exhibit A, and you have these exhibits before you, shows the average dollar amounts paid in indemnity to plaintiffs on behalf of individual physicians since 1988. The mean payment amount has risen by a compound annual growth of 6.9 percent over the past 10 years, as compared to 2.6 percent for the Consumer Price Index.

The data for this exhibit comes from the PIAA data-sharing project, a medical cause of loss database which was created in 1985 for the purpose of identifying common trends among malpractice claims, which are used for patient safety purposes by the PIAA member companies.

To date over 180,000 claims and suits have been reported. One very troubling aspect is the proportion of those claims and suits filed which are ultimately determined to be without merit. As shown on Exhibit B, 61 percent of all claims closed in 2001 were dropped or dismissed by the court. An additional 5.7 percent were won by the doctor at trial. Only 33 percent of all claims were found to be meritorious, with most of these being paid through settlement. When claims were concluded at verdict, the defendant prevailed an astonishing 80 percent of the time.

As shown on Exhibit C, the mean settlement amount on behalf of an individual defendant was just over $299,000. Most medical malpractice cases have multiple defendants, and thus these values are below those which may be reported on a case basis. The mean verdict amount last year was almost $497,000.

Exhibit D shows the mean expense payment for claims by category of disposition. As can be seen, the cost for taking a claim for each doctor named in a case all of the way through trial is fast approaching $100,000.

Exhibit E shows the distribution of claims payments at various payment thresholds. It can be readily seen that the number of larger payments, represented by the top segments on this exhibit, are growing as a percentage of the total number of payments. This is especially true for payments at or exceeding $1 million, which comprise almost 8 percent of all claims paid on behalf of individual doctors in 2001, as shown on Exhibit F. This percentage has doubled in the past 4 years.

Investment income is very important to insurers. We rely on it to offset premium needs. Medical malpractice insurers are 80 percent invested in high-grade bonds and have not lost large sums in the stock market. Brown Brothers Harriman, a leading investment and asset management firm, in a recent investment research report

states that over the last 5 years the amount medical malpractice companies have invested in equities has remained fairly constant.

In 2001, the equity allocation was 9 percent. As Exhibit G shows, medical liability insurance companies invested significantly less in equities than did all property casualty insurers. While insurers' interest income has declined due to falling market interest rates, when interest rates declined, bond values increased. This has had a beneficial effect in keeping total investment income level when measured as a percentage of total assets. This is shown on Exhibit H. Thus the assertion that insurers have been forced to raise their rates because of bad investments is simply not true.

The PIAA firmly believes that the adoption of effective Federal health care liability reforms as embodied in H.R. 5 will have a demonstrable effect on professional liability costs. The keystone of these reforms is the $250,0000 cap on noneconomic damages as passed in California over 25 years ago. These reforms are similar to the provisions of H.R. 4600 passed by the House last year and scored by the CBO as providing over $14 billion in savings to the Federal Government, an additional $7 billion to the States, because tort reforms works.

Using annual data published by the NAIC, Exhibit I documents the savings California practitioners and health care consumers have enjoyed since the enactment of MICRA over 25 years ago. As noted by the Chairman at the opening, total malpractice premiums reported to the NAIC since 1976 have grown in California by 167 percent, while premiums for the rest of the Nation have grown by 505 percent. These savings are clearly demonstrated in the rates charged to California doctors as shown on Exhibit J.

Successful experience in California and other States with tort reform, such as Wisconsin makes it clear that MICRA style tort reforms do work without lowering health care quality or limiting access to care.

The PIAA strongly urges Members of the Committee to support and adopt H.R. 5, which will ensure full payment of a truly injured patient's economic losses, as well as up to a quarter of a million dollars in noneconomic damages, thereby assuring fair compensation for patients, and also assuring Americans that they will be able to receive necessary health care services. Thank you.

Mr. SMITH. Thank you, Mr. Smarr.

[The prepared statement of Mr. Smarr follows:]

PREPARED STATEMENT OF LAWRENCE E. SMARR

INTRODUCTION

Chairman Sensenbrenner, Congressman Conyers and Committee Members, I am Lawrence E. Smarr, President of the Physician Insurers Association of America (PIAA). Thank you for allowing me the opportunity to appear before you today and speak about the need for the enactment of H.R.5, The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003.

As we all know, professional liability insurance premiums for doctors and hospitals are rapidly rising in many states to levels where they cannot afford to pay them. These increased premiums are caused by the ever-increasing size of medical liability insurance payments and awards. The unavoidable consequence is that physicians are moving away from crisis states, reducing the scope of their practices, or leaving the practice of medicine altogether. Likewise, hospitals are being forced to close facilities and curtail high-risk services because they can no longer afford to insure them.

DOCTORS INSURING DOCTORS

The PIAA is an association comprised of professional liability insurance companies owned and/or operated by physicians, dentists, and other health care providers. Collectively, our 43 domestic insurance company members insure over 300,000 doctors and 1,200 hospitals in the United States and our nine international members insure over 400,000 health care providers in other countries around the world. The PIAA member insurance companies can also be characterized as health care professionals caring for the professional liability risks of their colleagues—doctors insuring doctors, hospitals insuring hospitals. We believe that the physician owned/operated company members of the PIAA insure over 60% of America's doctors. Unlike the multi-line commercial carriers, medical liability insurance is all that the PIAA companies principally do, and they are here in the market to stay.

The PIAA was formed 26 years ago at a time when commercial insurance carriers were experiencing unanticipated losses and exited the market, leaving doctors, hospitals and other health care professionals no choice other than to form their own insurance companies. A quarter century has passed, and I am proud to say that the insurers who comprise the PIAA have become the driving force in the market, providing stability and availability for those they insure.

When the PIAA and many of its member companies were formed in the 1970's, we faced a professional liability market not unlike that which we are experiencing today. At that time, insurers, all of which were general commercial carriers, were experiencing rapidly increasing losses, which caused them to consider their continuance in the market. Many of the major carriers did indeed exit the market, leaving a void that was filled by state and county medical and hospital associations across the country forming their own carriers. Again we see the commercial carriers, such as St. Paul, exiting the market. But, this time, the provider owned carriers are in place and are indeed providing access to insurance and stability to the market.

Unfortunately, the recent exodus from and transformation of the market is of such magnitude that the carriers remaining do not have the underwriting capacity to take all comers. Facing ever-escalating losses of their own, many of the carriers remaining in the market are forced to tighten their underwriting standards and revise their business plans with regard to their nature and scope of operations. This includes the withdrawal from recently expanded markets, which adds to the access to insurance problem caused by carriers exiting altogether.

My goal here today is to discuss what the PIAA sees as the underlying causes of the current medical liability crisis. I want to stress that I believe that this situation should be characterized as a medical liability crisis, and not a medical liability insurance crisis. The PIAA companies covering the majority of the market are in sound financial condition. The crisis we face today is a crisis of affordability and availability of insurance for health care providers, and more importantly, the resulting growing crisis of access to the health care system for patients across the country.

INSURANCE INDUSTRY UNDERWRITING PERFORMANCE

Medical liability insurance is called a long-tail line of insurance. That is because it takes on average two years from the time a medical liability incident occurs until a resulting claim is reported to the insurer, and another two and one-half years until the average claim is closed. This provides great uncertainty in the rate making process, as insurers are forced to estimate the cost of claims which may ultimately be paid as much as 10 years after the insurance policy is issued. By comparison, claims in short-tail lines of insurance, such as auto insurance, are paid days or weeks after an incident.

Over the past three years medical liability insurers have seen their financial performance deteriorate substantially due to the rapidly rising cost of medical liability claims. According to A.M. Best (Best), the leading insurance industry rating agency, the medical liability insurance industry incurred $1.53 in losses and expenses for every dollar of premium they collected in 2001. While data for 2002 will not be available until the middle of this year, Best has forecast that the industry will incur $1.41 in losses and expenses in 2002, and $1.34 in 2003. The impact of insurer rate increases accounts for the improvement in this statistic. However, Best also calculates that the industry can only incur $1.14½ in losses and expenses in order to operate on a break-even basis. This implies that future rate increases can be expected as the carriers move toward profitable operations.

The physician owned/operated carriers that I represent insure a substantial portion of the market (over 60%). Each year, an independent actuarial firm (Tillinghast Towers-Perrin) provides the PIAA with a detailed analysis of annual statement data filed by our members with the National Association of Insurance Commissioners

(NAIC). This analysis is very revealing with regard to the individual components of insurers financial performance.

Exhibit 1 below details the operating experience of 32 physician owned/operated insurance companies included in the analysis. A widely relied upon insurance performance parameter is the combined ratio, which is computed by dividing insurers' incurred losses and expenses by the premiums they earn to offset these costs. For these companies, this statistic has been deteriorating (getting larger) since 1997, with major increases being experienced in 2000 and 2001.

## EXHIBIT 1

## FINANCIAL RATIOS TO NET PREMIUMS EARNED

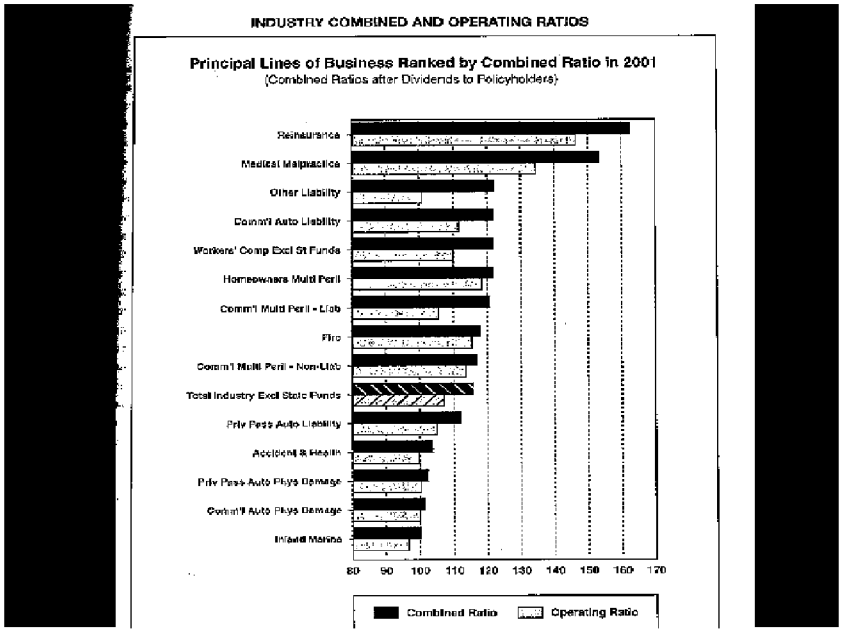
| | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 |
|---|---|---|---|---|---|---|---|
| Loss & LAE | 95% | 92% | 91% | 92% | 91% | 103% | 116 |
| Underwriting Exp | 15 | 17 | 19 | 22 | 22 | 21 | 22 |
| Combined Ratio | 110 | 109 | 111 | 114 | 113 | 124 | 138 |
| PH Dividends | 8 | 8 | 7 | 6 | 6 | 5 | 3 |
| Adj Comb Ratio | 119 | 118 | 118 | 120 | 119 | 129 | 141 |
| Net Inv Income | 49 | 44 | 45 | 43 | 34 | 33 | 31 |
| FIT | 7 | 7 | 6 | 6 | 2 | 1 | -1 |
| Net Income | 23 | 20 | 21 | 17 | 12 | 4 | -10 |

Source: Tillinghast Survey of PIAA Companies NAIC Filings

For calendar year 2001, the combined ratio (including dividends paid) was 141, meaning that total losses and dividends paid were 41% more than the premiums collected. Even when considering investment income, net income for the year was a negative ten percent. This follows a meager 4 percent net income in 2000. This average experience is indicative of the problems being experienced by insurers in general, and demonstrates the carriers' needs to raise rates to counter increasing losses. All of the basic components of the combined ratio calculation (loss and loss adjustment expense, underwriting expense) have risen as a percentage of premium for all years shown. The only declining component has been dividends paid to policyholders.

To compare this group of PIAA companies with the industry, Exhibit 2 is taken from the 2002 edition of *Best's Aggregates and Averages*. This shows that medical malpractice is the least profitable property and casualty line of insurance in 2001, following reinsurance, which has been greatly impacted by the World Trade Center losses. The adjusted combined ratio for the entire industry is 153, as compared to 141 for the PIAA carriers represented on Exhibit 1.

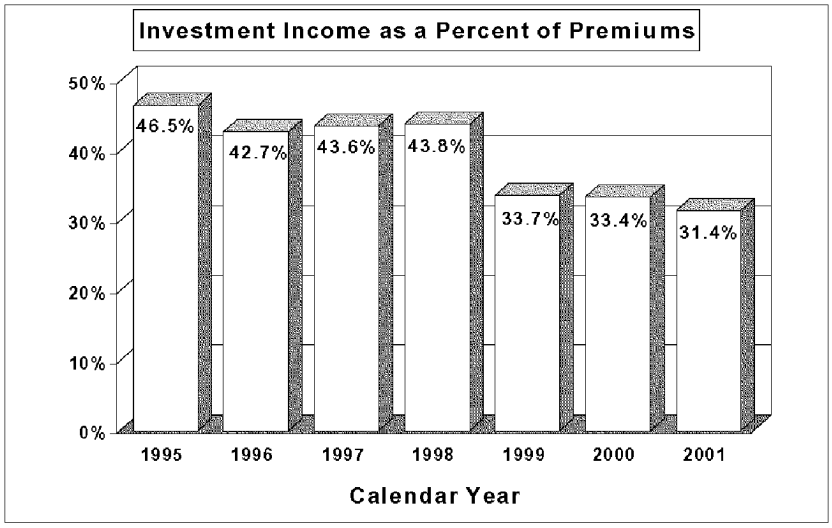
# EXHIBIT 2




THE ROLE OF INVESTMENT INCOME

Investment income plays a major role for medical liability insurers. Because medical liability insurance is a "long tail" line of insurance, insurers are able to invest the premiums they collect for substantial periods of time, and use the resulting investment income to offset premium needs. As can be seen on Exhibit 3, investment income has represented a substantial percentage of premium, and has played a major role in determining insurer financial performance. However, investment income as a percentage of premium has been declining in recent years primarily due to historic lows in market interest rates.

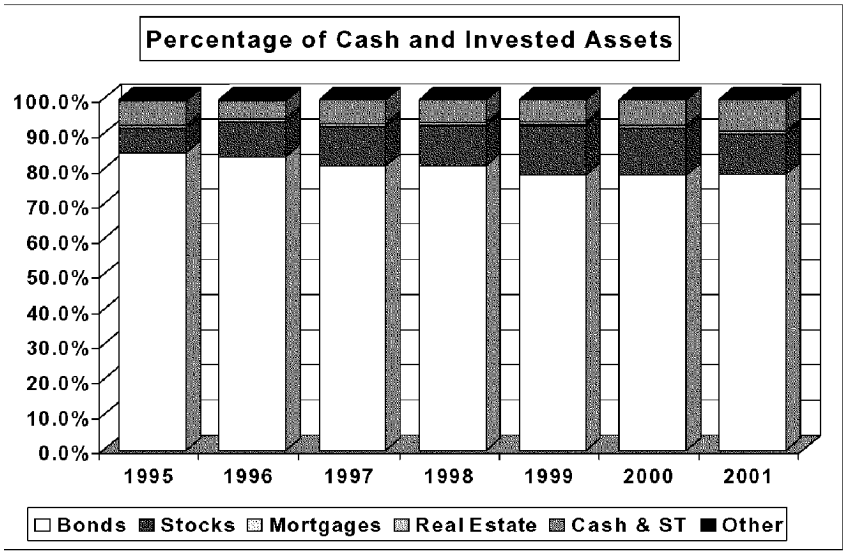
# EXHIBIT 3




Tillinghast - Towers Perrin 4

Contrary to the unfounded allegations of those who oppose effective tort reforms, medical liability insurers are primarily invested in high grade bonds and have not lost large amounts in the stock market. As can be seen in Exhibit 4, the carriers in the PIAA survey have been approximately 80% invested in bonds over the past seven years.

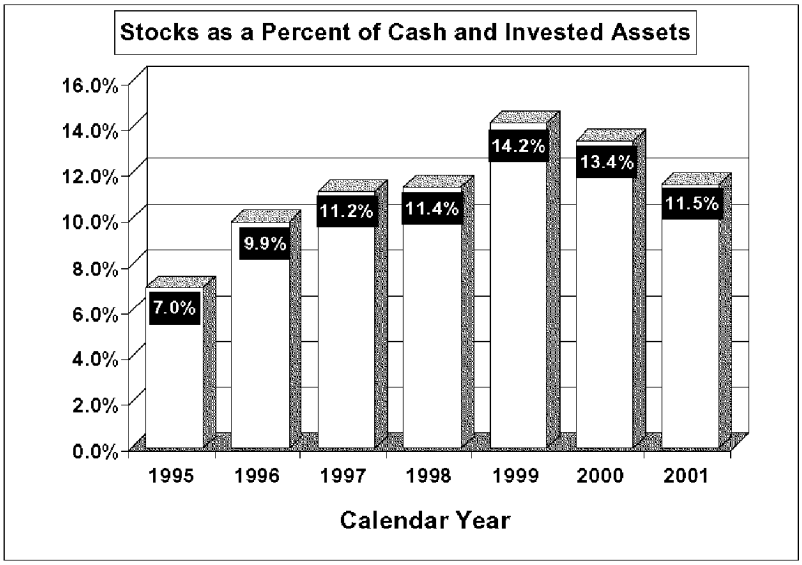
# EXHIBIT 4




Tillinghast-Towers Perrin 5

As shown on Exhibit 5, stocks have averaged only about 11% of cash and invested assets, thus precluding major losses due to swings in the stock market. Unlike stocks, high grade bonds are carried at amortized value on insurer's financial statements, with changes in market value having no effect on asset valuation unless the underlying securities must be sold.

# EXHIBIT 5

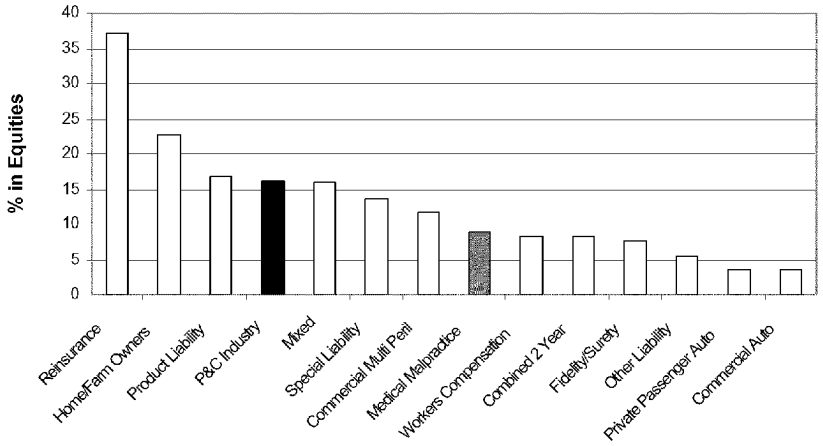



Milliman - Towers Perrin 6

The experience of the PIAA carriers is confirmed on an industry-wide basis through data obtained from the NAIC by Brown Brothers Harriman, a leading investment and asset management firm. Brown Brothers reports that "Over the last five years, the amount medical malpractice companies has invested in equities has remained fairly constant. In 2001, the equity allocation was 9.03%." As Exhibit 6 shows, medical liability insurers invested significantly less in equities than did all property casualty insurers.

EXHIBIT 6

**P&C Equity Allocation 2001**




**Source: Brown Brothers Harriman & Co., Insurance Industry Asset Allocation Study using NAIC data**

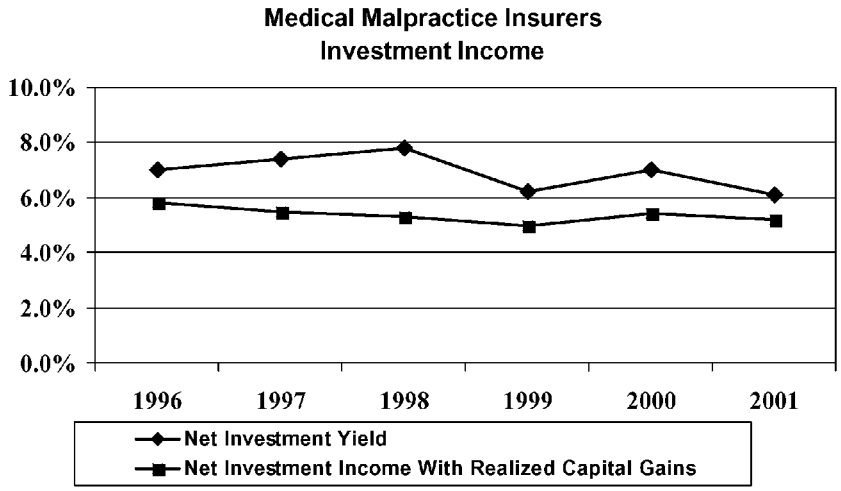
Brown Brothers states that the equity investments of medical liability companies ". . . had returns similar to the market as a whole. This indicates that they maintained a diversified equity investment strategy.

The Brown Brothers report further states:

> *Since medical malpractice companies did not have an unusual amount invested in equities and what they did was invested in a reasonable market-like fashion, we conclude that the decline in equity valuations is not the cause of rising medical malpractice premiums.*

While insurer interest income has declined due to falling market interest rates, when interest rates decline, bond values increase. This has had a beneficial effect in keeping total investment income level when measured as a percentage of total invested assets. This is shown in Exhibit 7 below. Thus, the assertion that insurers have been forced to raise their rates because of bad investments is simply not true.

EXHIBIT 7




Source: A.M. Best Aggregates & Averages, 1997 through 2002 Editions, (Predominantly Medical Malpractice Insurers).

THE INSURANCE CYCLE

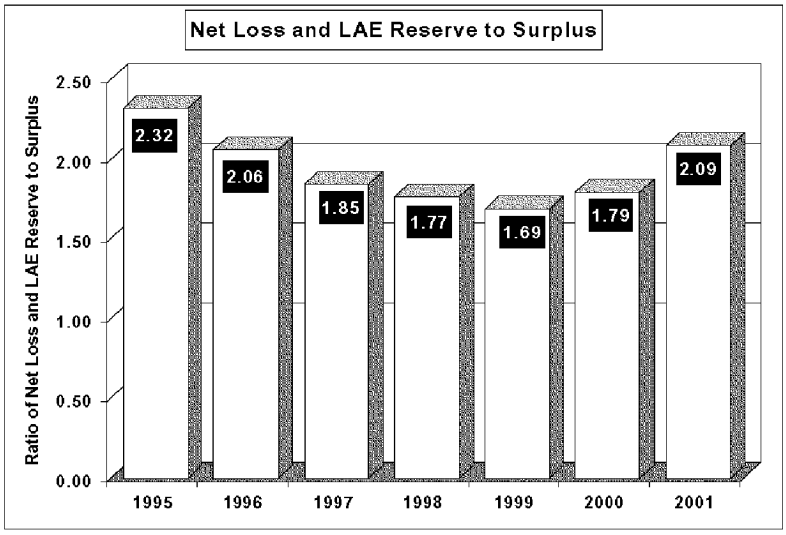
Opponents of effective tort reform claim that insurance premiums in constant dollars increase or decrease in direct relationship to the strength or weakness of the economy, reflecting the industry's investment performance. The researchers at Brown Brothers also tested this theory, and found no correlation between changes in generally accepted economic parameters (Gross Domestic Product (GDP) and 5-year treasury bond rates) with direct medical liability premiums written. In fact, Brown Brothers conducted 64 different regression analyses between the economy, investment yield, and premiums, and found no meaningful relationship. The report produced by Brown Brothers states:

> *Therefore, we can state with a fair degree of certainty that investment yield and the performance of the economy and interest rates do not influence medical malpractice premiums.*

INSURER SOLVENCY

A key measure of financial health is the ratio of insurance loss and loss adjustment expense (amounts spent to handle claims) reserve to surplus. This ratio has deteriorated (risen) for the PIAA carriers since 1999 to a point where it is approximately two times the level of surplus, as shown on Exhibit 8 below.

# EXHIBIT 8



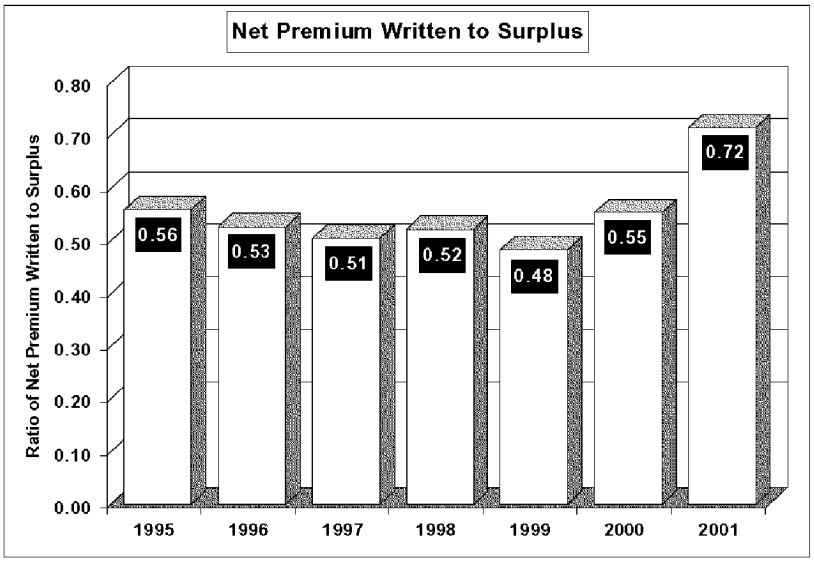

Tillinghast - Towers Perrin 9

The relationship between reserves (amounts set aside to pay claims) and surplus is important, as it is a measure of the insurer's ability to contribute additional amounts to pay claims in the event that original estimates prove to be deficient. *At the current approximately two-to-one ratio, these carriers in aggregate are still in sound financial shape.* However, any further deterioration in surplus due to underwriting losses will cause a deterioration in this important benchmark ratio indicating an impairment in financial condition. Under current market conditions, characterized by increasing losses and declining investment interest income, the only way to increase surplus is through rate increases.

Net premiums written as compared to surplus is another key ratio considered by regulators and insurance rating agencies, such as A.M. Best. This statistic for the companies in the PIAA survey has also been deteriorating (rising) since 1999, showing a 50% increase in the two years ending in 2001. The premium-to-surplus ratio is a measure of the insurer's ability to write new business. In general, a ratio of one-to-one is considered to be the threshold beyond which an insurer has over-extended its capital available to support its underwritings.

As can be seen on Exhibit 9, this statistic has also deteriorated, and the carriers in aggregate are approaching one-to-one. As the carriers individually approach this benchmark, they will begin to decline new risks, causing further availability problems for insureds. Rate increases the carriers are taking also have an impact on this important ratio as well as new business written.

# EXHIBIT 9




THE CAUSE OF THE CRISIS

The effects described in the previous pages were caused by the convergence of six driving factors making for the perfect storm, as follows:

- Dramatic long term paid claim severity rise
- Paid claim frequency returning and holding at high levels
- Declining market interest rates
- Exhausted reserve redundancies
- Rates becoming too low
- Greater proportion of large losses

The primary driver of the deterioration in the medical liability insurance industry performance has been paid claim severity, or the average cost of a paid claim, and their associated expenses. The National Association of Insurance Commissioners (NAIC) confirmed this in a February 7, 2003 letter to Senator Judd Gregg, which states in part: "The preliminary evidence points to rising loss costs and defense costs associated with litigation as the principal drivers of medical malpractice prices." (letter attached)

# EXHIBIT 10

## Average and Median Claim Payments
### PIAA Data Sharing Project

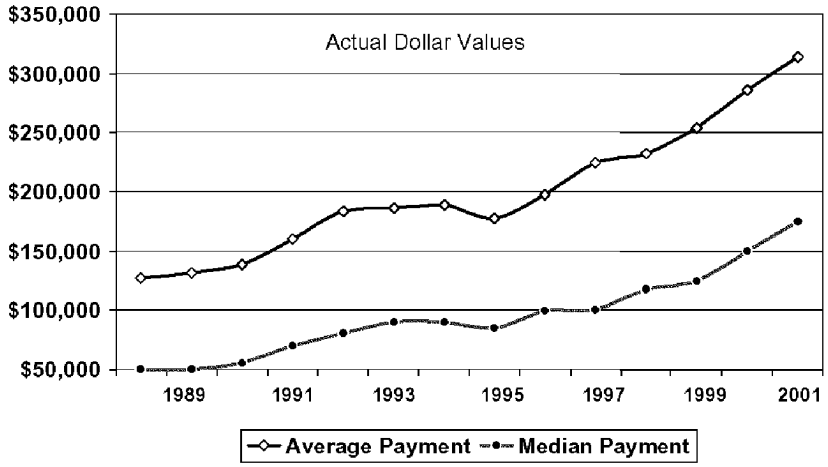
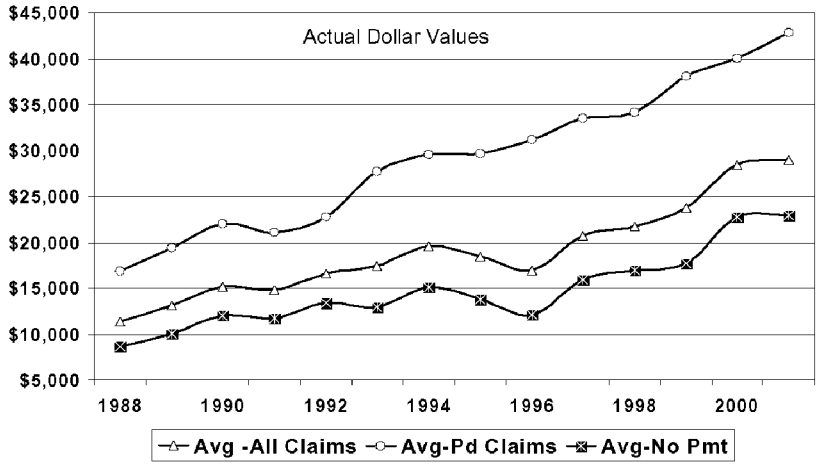



Exhibit 10 shows the average dollar amount paid in indemnity to plaintiffs on behalf of individual physicians since 1988. The mean payment amount has risen by a compound annual growth of 6.9% during this period, as compared to 2.6% for the Consumer Price Index (CPIu). The data for Exhibit 10, as well as that for slides which follow, comes from the PIAA Data Sharing Project. This is a medical cause-of-loss database, which was created in 1985 for the purpose of identifying common trends among malpractice claims. PIAA member companies use the database for risk management and patient safety purposes. To date, over 180,000 claims and suits have been reported to the database.

Allocated loss adjustment expenses (ALAE) for claims reported to the Data Sharing Project have also risen at alarming rates. ALAE are the amounts insurers pay to handle individual claims, and represent payments principally to defense attorneys, and to a lesser extent, expert witnesses. Average amounts paid for three categories of claims are shown below. As can be seen, the average amount spent for all claims in 2001 has risen to just under $30,000.

# EXHIBIT 11

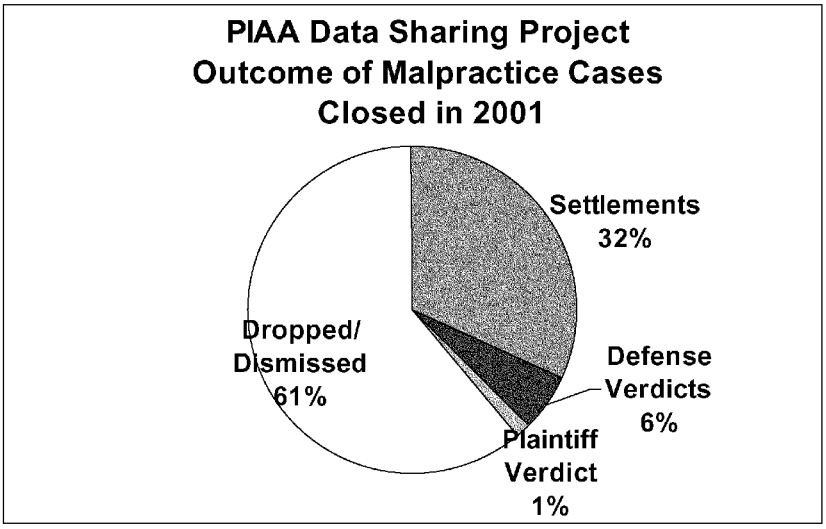
## Average Expense Payment Values
### PIAA Data Sharing Project




One very troubling aspect of medical malpractice claims is the proportion of those filed which are ultimately determined to be without merit. Exhibit 12 shows the distribution of claims closed in 2001 as reported to the PIAA Data Sharing Project. Sixty-one percent of all claims filed against individual practitioners were dropped or dismissed by the court. An additional 5.7% were won by the doctor at trial. Only 33.2% of all claims closed were found to be meritorious, with most of these being paid through settlement. Of all claims closed, more than two-thirds had no indemnity payment to the plaintiff. When the claim was concluded at verdict, the defendant prevailed an astonishing 80% of the time. This data clearly shows that those attorneys trying these cases are woefully deficient in recognizing meritorious actions to be pursued to conclusion.

Analyses performed by the PIAA have shown that of all premium and investment income available to pay claims, only 50% ever gets into the hands of truly injured patients, with the remainder being principally paid to attorneys, both plaintiff and defense. Something is truly wrong with any system that consumes 50% of its resources to deliver the remainder to a small segment of those seeking remuneration.

EXHIBIT 12




A review of the average claim payment values for the latest year reported to the PIAA Data Sharing Project (2001) is revealing. As shown on Exhibit 13, the mean settlement amount on behalf of an individual defendant was just over $299,000. Most medical malpractice cases have multiple defendants, and thus, these values are below those, which may be reported on a per case basis. The mean verdict amount last year was almost $497,000 per defendant.

EXHIBIT 13

**PAYMENT VALUES – 2001**

**As of 09/04/02**

| | |
|---|---|
| **Mean Indemnity Payment** | **$310,215** |
| **Mean Settlement** | **$ 299,003** |
| **Mean Verdict** | **$ 496,726** |

Exhibit 14 shows the mean expense payment for claims by category of disposition. As can be seen, the cost of taking a claim for each doctor named in a case all the way through trial is fast approaching $100,000.

EXHIBIT 14

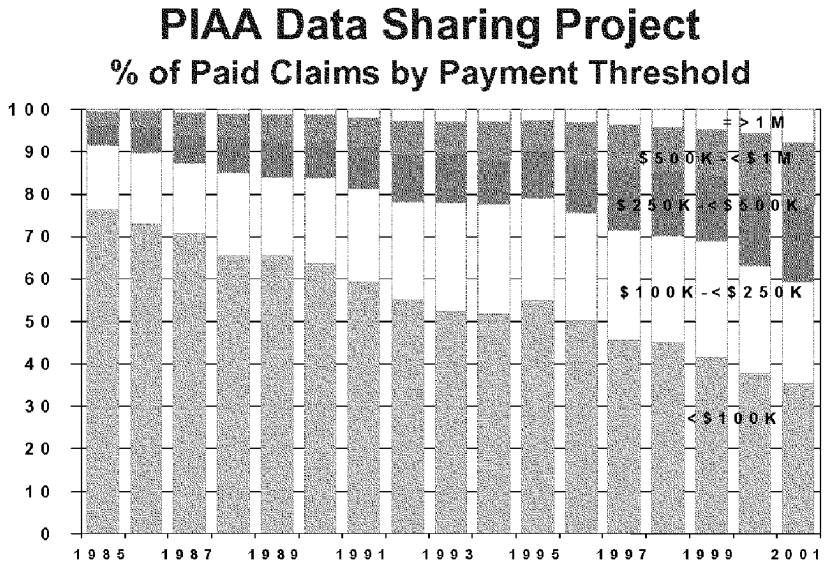
## PAYMENT VALUES – 2001

As of 09/04/02

| | |
|---|---|
| **Mean Indemnity Payment** | **$310,215** |
| **Mean Expense Payment** | **$ 28,801** |
| **Won at Trial** | **$ 85,718** |
| **Lost at Trial** | **$ 91,423** |
| **Settled** | **$ 39,891** |
| **Dropped/Dismissed** | **$ 16,743** |

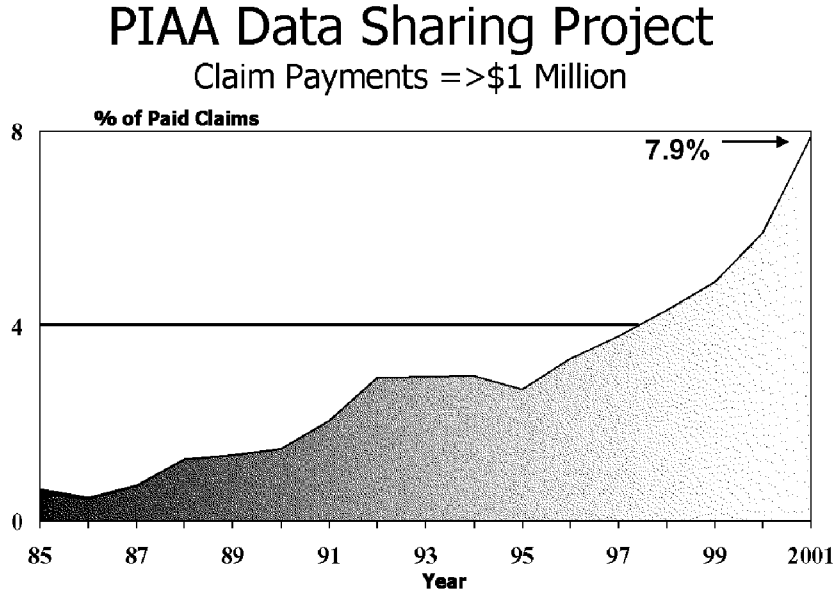
Exhibit 15 shows the distribution of claims payments at various payment thresholds. It can be readily seen that the number of larger payments are growing as a percentage of the total number of payments.

# EXHIBIT 15




This is especially true for payments at or exceeding $1 million, which comprised almost eight percent of all claims paid on behalf of individual practitioners in 2001 (Exhibit 16). This percentage has doubled in the past four years, and clearly demonstrates why insurers are facing dramatic increases in the amounts they have to pay for reinsurance. While medical liability insurers are reinsured by many of the same companies having high losses from the World Trade Center disaster, their medical liability experience was rapidly deteriorating prior to September 11, 2001.

EXHIBIT 16




In addition to rising claim severity, like all other investors, medical liability insurers have faced declining market interest rates. Eighty percent of PIAA insurers' investments are placed in high-grade bonds. Exhibit 17 shows the long-term decline in high-grade bond earnings. As can be seen, this is not a recent phenomenon, but a long term trend.

Critics of the medical liability insurance industry say that insurers' reliance on investment income to offset premiums has caused turmoil in the marketplace, implying that the use of investment income is a bad thing. Nothing could be further from the truth. If insurers did not ever use investment income to offset premium needs, then rates would always be 30–40% higher than otherwise necessary. The role market interest rates play in determining pricing in medical liability insurance (and other lines as well) is a fact of life which we cannot control.

# EXHIBIT 17

## MOODY'S LT AAA BONDS
## Average Yield to Maturity


Source: US Federal Reserve Bank 05/28/2002

THE ANSWER

Medical liability insurers and their insureds have faced dramatic long-term rises in paid claim severity, which is now at historically high levels. Paid claim frequency (the number of paid claims) is currently remaining relative constant, but has risen significantly in some states. While interest rates will certainly rise and fall in future years, nothing has been done over the past three decades to stem the ever-rising values of medical malpractice claim payments or reduce the number of meritless claims clogging up our legal system at great expense—except in those few states that have effective tort reforms. In many states not having tort reforms, costs have truly become excessive, and insurers are forced to set rates at levels beyond the abilities of doctors and hospitals to pay. States having tort reforms, such as California, provide a compelling example that demonstrates how such reforms can lower medical liability costs and still provide adequate indemnification for patients harmed as a result of the delivery of health care.

The following reforms are those which the PIAA advocates be adopted at the federal level, which we also feel should be the standard for any state reforms enacted. They are based on the reforms found in the Medical Injury Compensation Reform Act (MICRA) which became effective in California in 1976 and which have been successful in compensating California patients and ensuring access to the health care system since their enactment.

# EXHIBIT 18

## Health Care Liability Reform

- $250,000 cap on non-economic damages
- Collateral source offsets
- Periodic payment of future damages
- 1/3 year statute of limitations/repose
- Joint and several liability
- Contingency fee limits

The keystone of the MICRA reforms is the $250,000 cap on non-economic damages (pain and suffering) on a per-incident basis. Under MICRA, injured patients receive full compensation for all quantifiable damages, such as lost income, medical expenses, long-term care, etc. In addition, injured patients can get as much as one-quarter million dollars for pain and suffering. Advising juries of economic damages that have already been paid by other sources serves to reduce double payment for damages. An important component of MICRA is a reasonable limitation on plaintiff attorney contingency fees, which can be 40% or more of the total amount of the award. Under MICRA, a trial lawyer must be satisfied with only a $220,000 contingency fee for a $1 million award.

A Gallup poll published on February 5, 2003 by the National Journal indicates that 57% of adult Americans feel there are too many lawsuits against doctors, and 74% feel that we are facing a major crisis regarding medical liability in health care today. Seventy-two percent of respondents favored a limit on the amount that patients can be awarded for their emotional pain and suffering. Only the trial lawyers and their front groups disagree, seeing their potential for remuneration being reduced. Especially displeasing to them is MICRA's contingency fee limitation, which puts more money in the hands of the injured patient (at no cost reduction to the insurer).

The U.S. House of Representatives adopted legislation containing tort reforms similar to MICRA, including a $250,000 cap on non-economic damages, for the seventh time in September of last year. HR 4600, known as the HEALTH Act, was introduced and adopted on a bi-partisan basis. The Congressional Budget Office (CBO) conducted an extensive review of the provisions of HR 4600, and reported to Congress that if the reforms were enacted, ". . . premiums for medical malpractice insurance ultimately would be an average of 25 percent to 30 percent below what they would be under current law."

The CBO found that HR 4600 reforms would result in savings of $14.1 billion to the federal government through Medicare and other health care programs for the period 2004–2012. An additional $7 billion of savings would be enjoyed by the states through their health care programs. The CBO's analysis did not consider the effects

that federal tort reform would have on reducing the incidence of defensive medicine, but did acknowledge that savings were likely to result.

EXHIBIT 19

# CBO Scoring of HR 4600

**September 24, 2002**

**$14.1 Billion Savings 2004 – 2012**

**$7 Billion Savings to the States 2004 - 2012**

**"…premiums for medical malpractice insurance ultimately would be an average of 25 percent to 30 percent below what they would be under current law."**

The US Department of Health and Human Services published a report on July 24, 2002, which evaluated the effects of tort reforms in those states that have enacted them. As stated in Exhibit 20, HHS found that practitioners in states with effective caps on non-economic damages were currently experiencing premium increases in the 12–15% range, as compared to average 44% increases in other states.

EXHIBIT 20

# USDHHS

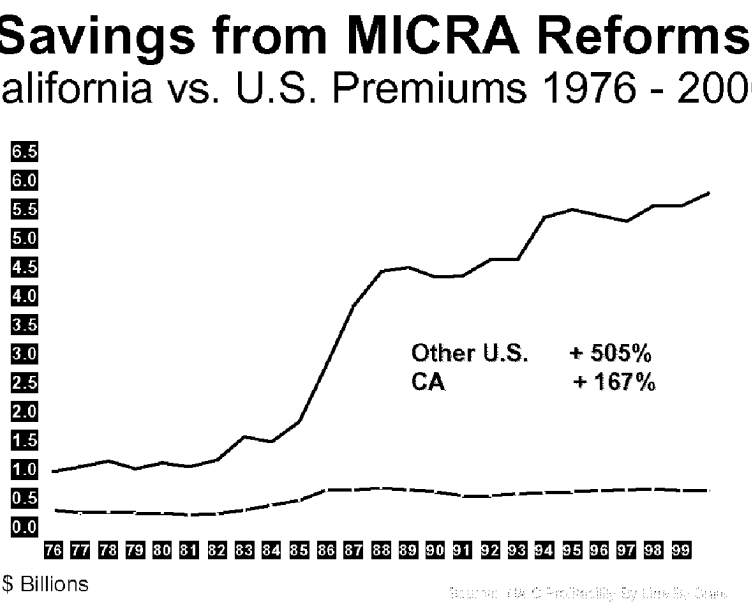
***Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System***

***July 24, 2002***

**"States with limits of $250,000 or $350,000 on non-economic damages have average combined highest premium increases of 12 – 15%, compared to 44% in states without caps…"**

Annual data published by the National Association of Insurance Commissioners (NAIC) also documents the savings California practitioners and health care consumers have enjoyed since the enactment of MICRA over 25 years ago. As shown in Exhibit 21, total medical liability premiums reported to the NAIC since 1976 have grown in California by 167%, while premiums for the rest of the nation have grown by 505%. These savings can only be attributed to MICRA.

EXHIBIT 21




These savings are clearly demonstrated in the rates charged to California doctors as shown in Exhibit 22. Successful experience in California and other states makes it clear that MICRA style tort reforms do work without lowering health care quality or limiting access to care.

EXHIBIT 22

## 2002 Rates- $1mil/3mil Coverage
(as reported by Medical Liability Monitor)

| | LA[1] | Mil-waukee[2] | Chicago[3] | Phila[4] | Miami[5] |
|---|---|---|---|---|---|
| IM | 11,164 | 5,148 | 26,404 | 18,429 | 56,153 |
| GS | 36,740 | 18,020 | 68,080 | 82,157 | 174,268 |
| OB/ Gyn | 54,563 | 27,802 | 102,640 | 100,045 | 201,376 |

1 The Doctors Company
2 PIC Wisconsin
3 ISMIE Mutual Insurance Company
4 Pennsylvania Medical Society Liability Insurance Company
5 First Professional Insurance Company

PROP 103 HAD NO EFFECT ON CALIFORNIA MEDICAL LIABILITY PREMIUMS

In an effort to derail desperately needed tort reforms as described above, the Association of Trial Lawyers of America and related individuals and groups have stated that the beneficial effects of MICRA as shown on Exhibit 21 are due to Proposition 103, a ballot initiative passed in 1988 aimed primarily at controlling auto insurance costs. The ballot initiative passed by a 51% majority vote, with voters in only 7 of California's 58 counties approving the measure. The major changes made by Prop 103 include:

- Making the insurance commissioner of California an elected, rather than appointed, official;
- Giving the insurance commissioner authority to approve rate changes before they can take effect;
- Requiring insurers to reduce rates by 20 percent from their levels on November 8, 1987;
- Requiring auto insurance companies to offer a 20 percent "good driver discount."
- Requiring auto insurance rates to be determined primarily by four factors;
- Allowing for payment of "intervenor fees" to outside groups that intervene in hearings conducted by the Department of Insurance.

Medical liability insurers were not the intended target of Prop 103, but were covered by the resulting regulations. However, Prop 103 did not have any substantive effect on reducing medical liability insurance rates. Prop 103 did have the effect of freezing most insurance rates in California until as late as 1994. This all came at a time when medical liability insurers across the nation were seeing their rates level off or even decline.

Prop 103 added a provision to the California Insurance Code at Section 1861.01, which required insurers to roll back their rates to 20 percent lower than those in effect on November 8, 1987. However, this is not what happened to medical malpractice insurers.

One major California insurer, the NORCAL Mutual Insurance Company reached the very first consent agreement of any insurer with the California Department of Insurance in November of 1991. To satisfy the requirements of Prop 103, NORCAL was specifically permitted to declare a one-time 20% return of premium for policyholders insured between November 8, 1988 and November 8, 1989 as a dividend by March 31, 1992. NORCAL was not required to roll back its rates as a result of Prop 103. As NORCAL was already paying dividends exceeding 20% per year during the

period in question, no additional monies were returned to policyholders as a result of Prop 103. The experience of other California physician owned companies, such as The Doctors' Company and the Medical Insurance Exchange of California, was similar to that of NORCAL. Even if California medical liability insurers had been required to reduce rates by 20%, this in no way could explain the wide gap in experience shown on Exhibit 21.

CONCLUSION

Increasing medical malpractice claim costs, on the rise for over three decades, have finally reached the level where the rates that insurers must charge can no longer be afforded by doctors and hospitals. These same doctors and hospitals cannot simply raise their fees, which are limited by government or managed care companies. Many doctors will face little choice other than to move to less litigious states or leave the practice of medicine altogether.

Legislators are now challenged with finding a solution to the medical liability insurance affordability and availability dilemma—a problem long in coming that has truly reached the crisis stage. The increased costs being experienced by insurers (largely owned/operated by health care providers) are real and documented. It is time for Congress to put an end to the wastefulness and inequities of our tort legal system, where only 50% of the monies available to pay claims are paid to indemnify the only 30% of claims filed with merit and the expenses of the remainder. The system works fine for the legal profession, which is why trial lawyers and others fight so hard to maintain the status quo.

The PIAA strongly urges members of the House to pass effective federal health care liability reform, thereby stopping the exodus of health care professionals and institutions which can no longer afford to fund an inequitable and inefficient tort system which benefits neither injured plaintiffs or the health care community.

Mr. SMITH. And thank you all again for your testimony.

Mr. Smarr, let me direct my first question to you, and it is this: We know for a fact, for example, that jury awards have doubled in the last 5 years. We also know that 70 percent of all lawsuits filed against health care providers result in no payment; they may be frivolous. Those are going to have a dramatic impact on insurance premiums. So my question is this: If we enact the HEALTH Act, if that becomes law, do you expect the medical malpractice insurance premiums to at least not increase as projected, to increase as fast as expected?

Mr. SMARR. Yes. We expect that if the HEALTH Act is adopted, and it stands constitutional challenge, that we will see medical malpractice stop their increase, and we will ultimately see medical malpractice premiums go down. The Congressional Budget Office in its scoring of H.R. 4600 stated that if that bill were passed into law, that malpractice premiums would be 25 to 30 percent lower than they would otherwise have been.

Mr. SMITH. Dr. Palmisano, if the HEALTH Act becomes law, what impact will that have on health care available to Americans generally, and also specifically to health care available to women, lower-income individuals, and those who live in rural areas?

Dr. PALMISANO. Passage of H.R. 5 would have a favorable effect on access to care. And the States that have stable liability climates, California, Louisiana, Indiana, New Mexico, Colorado and Wisconsin, are States that have patients who have access to care. So it would be very favorable.

Mr. SMITH. Thank you, Dr. Palmisano.

Mrs. Dyess, you today were speaking not only on behalf of your husband, but on behalf of thousands and thousands of other individuals who might not have received proper care because of a broken health care system, and you obviously feel that it is not the fault of the doctors that a specialist was not available to help your

husband when he needed help. A lot of people would have suggested that you file suit against the hospital. Why did you not think this was the proper action to take?

Ms. DYESS. Never entered my mind. It never—my husband's care was of utmost importance to me. I felt like the hospital did everything they possibly could do in order to get him the help that he needed to have.

Mr. SMITH. You feel it wouldn't solve the problem for you to file suit because a specialist wasn't available?

Ms. DYESS. Filing a suit is not going to bring back my husband's brain. It is not going to help anything. It is not the right thing to do. It is not their fault.

Mr. SMITH. And again, though, your point is that you want to make proper care available to more people, and the way to do that is not to have doctors' insurance premiums go up so much that they are either priced out of the market, they don't practice medicine, or they reduce their practice.

Ms. DYESS. Absolutely.

Mr. SMITH. Thank you, Mrs. Dyess.

Mrs. Keller, it is my understanding that no settlement or award has been determined in your case yet; is that right?

Ms. KELLER. That is correct. Still in the court system.

Mr. SMITH. I also recognize that whatever the amount might be, you would gladly trade it to have your health back and a normal life back as well?

Ms. KELLER. Exactly.

Mr. SMITH. You also, I assume, want the victims of medical malpractice to be compensated, and I would have to say that we all do. If physicians have made a mistake, the victims ought to be compensated. But I just wanted to also make you aware that in the HEALTH Act that we are considering today, a lot of the expenses that you thought were not going to be covered will, in fact, be covered. Any expense you have a receipt for, any health care provider that helps you with chores, all of those individuals, you will be reimbursed for the cost of all of those individuals. So it is maybe not as limited as you might think.

I also wanted to point out, in the time that I have left, that just because there is a cap on noneconomic damages doesn't mean there can't be fair and sufficient and adequate awards. The three examples that occurred in California just in the last year, you had a 5-year-old boy who received the $84 million that I mentioned in my statement, a 3-year-old girl received $59 million, and a 30-year-old homemaker with brain damage received over $12 million.

In other words, you do get compensated for lost wages, for all medical care, for all rehabilitation expenses and so forth. Obviously that can amount to tens of millions of dollars. So I don't want you to think that you are going to be left with an inadequate amount under the HEALTH Act that we are having a hearing on today. There can oftentimes be very substantial compensation, and that is simply the point I wanted to make.

But, again, thank you for your very compelling testimony here today. That concludes my questions.

The gentleman from Michigan, the Ranking Member of the Judiciary Committee.

Mr. CONYERS. I will yield to Mr. Berman.

Mr. SMITH. The gentleman from California, Mr. Berman, is recognized for his questions.

Mr. BERMAN. Well, thank you very much, Mr. Chairman.

Dr. Palmisano, what this legislation does is essentially takes a number of the changes made in California law in 1975 and seeks to provide it as a Federal law that would preempt any less strict limits that now exist in the other 49 States; is that a fair statement?

Dr. PALMISANO. It is my understanding, sir, that this law has—that this bill, H.R. 5, has a flexibility provision. So if the State of Florida, Michigan, Colorado, whatever, that if they wanted to have a cap of $500,000, the legislature could do that. It also provides——

Mr. BERMAN. What, if they have a cap of $500,000 now?

Dr. PALMISANO. It would remain in place.

Mr. BERMAN. What if they don't have a cap?

Dr. PALMISANO. The Federal law, H.R. 5, if it was enacted into law, would be the cap for that State. They would have the flexibility to change it.

Mr. BERMAN. And if it were a $5 million cap on pain and suffering?

Dr. PALMISANO. If it was a $5 million cap in that State, it would remain a $5 million cap in that State.

Mr. BERMAN. You are telling States who may not like the $250,000 cap on pain and suffering, if you can put a bill through and get it signed into law prior to the effective date of this law, that cap is okay?

Dr. PALMISANO. No, sir. They can do it after the law, too. If this becomes law, they——

Mr. BERMAN. The only thing you can't do is be uncapped? You can have a cap that has never been reached, but you can't be uncapped; is that what you are saying?

Dr. PALMISANO. Yes, sir. For instance——

Mr. BERMAN. Okay. Good.

When California passed its bill—first, I think we should just note for the record that the Majority staff report incorrectly states, not intentionally, I think they picked up a Health and Human Services Department report, I guess is—the Department of HHS, in order to sort of stick it to them in a way, said that while Henry Waxman, Chairman of the Select Committee on Medical Malpractice in 1973 and 1974, proposed the limits that became MICRA that are now this law. And specifically the cap on pain and suffering of $250,000, Health and Human Services got it wrong, and as a result of that, this Committee analysis is in error in that sense, because the select Committee never proposed a limit on pain and suffering of $250,000.

But that law at that time created a whole series of other changes, strengthened medical discipline, made it easier to discipline bad doctors, provided higher levels of immunity to physicians on a hospital committee who could then testify about the practices of a doctor that they felt should have his privileges revoked, and protect those people against being sued by that doctor, far greater reporting requirements. In other words, there was a notion, yes, we are going to put some limits on the liability system,

but we recognize the problem of doctors who aren't performing up to a reasonable standard, and we are going to make it tougher for them to practice medicine.

I notice nothing in this bill that deals—seeks to federalize the program or compel States to have certain standards of discipline and reporting for doctors who are not meeting the appropriate standard of care.

And I guess aren't you a little embarrassed that you are cherry-picking a series of provisions here, claiming that California has had great success? You have produced charts, you point out those limits, you claim you are taking those limits and putting them in Federal law, collateral source rule, periodic payments, cap on pain and suffering, limitations on contingency fees, and then totally ignoring any efforts to try and strengthen regulation of the medical profession such as was done in California, including even things like allowing other physicians to have immunity if they seek to revoke a bad physician's malpractice. Aren't you a little embarrassed by that?

Dr. PALMISANO. Well, the California MICRA law has the elements that you mentioned, the periodic payments, the contingency fee——

Mr. BERMAN. Tougher medical discipline, tougher immunity provisions to protect doctors who want to testify, requirements that every hospital report to the State board of medical quality assurance acts of negligence and malpractice suits. Aren't you embarrassed that those aren't in this bill?

Dr. PALMISANO. I am not embarrassed, because the Health Care Quality Improvement Act, which was a Federal law, which was passed later than that, requires that any dollar paid on behalf of a physician gets reported to the Federal Government, and also gets reported to the State board of medical examiners.

And so we strongly support State boards of medical examiners being adequately funded to do the proper investigation so that every case is looked at by the State board to make sure if there is any disciplinary situation that needs to be done or anyone's license revoked——

Mr. BERMAN. Would you be willing to incorporate those—the reporting requirements, to the extent that they are stronger than that exists at Federal law now, the reporting requirements, the immunity provisions, and the disciplinary authorities mandating that any State that wants to take advantage and have these limits apply also adjust their laws to provide that level of protection against malpracticing physicians? Would you be willing to accept that kind of an amendment to this legislation?

Dr. PALMISANO. Well, the AMA policy would be to look at any language that was offered. We do know that we support the——

Mr. BERMAN. How about a top-of-the-head reaction?

Dr. PALMISANO. Well, I am not speaking for myself. I am speaking for the American Medical Association. The American Medical Association believes in strong physician discipline, and we have policy on that. It is all on the AMA Website in Policy Finder. We also strongly support patient safety. That is why we founded the National Patient Safety Foundation.

Mr. BERMAN. And where State law doesn't meet the kinds of requirements that exist in MICRA, could I then—would it be logical to conclude that it would be appropriate for the Federal Government to mandate that each State meet that minimum standard of discipline, regulation, immunity, encouraging testimony by other physicians?

Dr. PALMISANO. Again, anything that would be offered would be reviewed by the AMA to see how it fits for policy.

Mr. BERMAN. Thank you for your helpful advice.

Mr. SMITH. Thank you, Mr. Berman. The gentleman from Florida, Mr. Keller, is recognized for his questions.

Mr. KELLER. Thank you, Mr. Chairman.

I can tell you there absolutely is a medical liability crisis in my home State of Florida. Just this week our major hospital in my district, Orlando Regional Medical Center, announced it will close its Level 1 Trauma Center, which is the only center within 3 or 4 hours to treat head injuries such as those suffered by Mrs. Dyess' husband because the neurosurgeons can no longer pay the medical liability premiums. So it is a real problem facing a lot of physicians throughout this country.

I appreciate you, Mrs. Keller. I especially like your last name. I appreciate your courage, which it took quite a bit to come here and testify today. I know everybody is very sympathetic to your case.

The Chairman pointed out that we don't yet have a verdict or settlement amount in your case, but you said if you had Bill Gates' money, you wouldn't trade it for your injuries. I agree. You seem like a straightforward person. The challenge facing those of us in Congress, though, is if we allowed a jury to give you Bill Gates' money, which is approximately $40 billion, then you are still not going to be made whole, that hospital is going to be shut down, and thousands of people are going to be denied access to medical care.

Ms. KELLER. And so what we have got to do is find the strike zone somehow, so that you are at least fairly compensated and yet we still have access to health care and us to of people who need it, and so we are trying to sort our way through this to make sure we get the fairest result.

I would like to play devil's advocate a little bit, Mr. Smarr, to you and ask you a few questions here. Some say that if Congress passes this $250,000 cap on noneconomic damages, the insurance companies aren't going to pass on these savings to the doctors. They are just going to put it in their pocket and they won't lower premiums. What do you say to that?

Mr. SMARR. I don't believe that that is correct. As I have testified, the majority of doctors in America are insured by companies that are owned and are operated by doctors. These companies operate largely for the benefit of their insureds and are dedicated to providing a stable market and charging a fair price for their insurance. And once this law goes into effect, this is going to enhance competition. The insurers that have gotten out of the market are going to come back in; and that competition, if for no other reason, that competition is going to drive prices down.

Mr. KELLER. To the best of your knowledge the insurance companies you represent will lower their premiums?

Mr. SMARR. I believe they will once they can be assured that the law sticks.

Mr. KELLER. Let me ask you something else that opponents of this legislation point out. They say insurance companies are just jacking up doctors' premiums this year because they lost a bunch of money in the stock market, not because of any medical liability crisis. What do you say to that?

Mr. SMARR. There are two comments here. First of all, insurers have not lost large amounts in the stock market; they are primarily invested in bonds. And secondly, the State insurance departments which approve rates will not allow an insurer to take any type of prior-year losses, whether it be from underwriting or investment, and impute those values in their future rates. It would be illegal for them to do that.

Mr. KELLER. So when you say "a small percent in the stock market," give me an idea; for example, one of your major companies, what percent?

Mr. SMARR. Ten percent of their investments are in equities.

Mr. KELLER. Okay. And over 90 percent aren't, then.

Mr. SMARR. Ninety percent aren't. That is correct.

Mr. KELLER. Okay. Another thing opponents say is that that 1975 California law, MICRA, that capped the noneconomic damage at 250 really didn't have anything to do with the malpractice premiums being stabilized in California. It was really Prop 103, a constitutional amendment which dealt mostly with car insurance, I guess. But they are saying that is what held medical liability insurance premiums down. What are your thoughts on that?

Mr. SMARR. Well Prop 103 had nothing to do with it. As you state, it was an auto initiative primarily. However, all property and casualty insurance conditions were covered by its provisions. Prop 103 required that insurers roll back their rates to 20 percent below those in effect on, I believe it was, November 8 of 1987. Prop 103 was passed in 1988. This was immediately challenged by the insurance industry. And not until 1991 was some progress made in this regard. The very first insurance company that reached agreement with the California insurance commissioner about how to handle Prop 103 was one of my members called NorCal Mutual Insurance Company. NorCal reached a consent agreement with the commissioner whereby they were required to refund 20 percent of 1 year's premiums, which they could then pay as a normal dividend, but they were not required to roll back their rates at all. At that point in time, NorCal was paying far in excess of 20 percent annual dividends per year.

Mr. KELLER. So if it had any effect, it would have only been for 1 year.

Mr. SMARR. And really had no effect. It was part of the normal dividend cycle. Same thing true for other carriers.

Mr. KELLER. Let me ask one more question. Dr. Palmisano, some say that this sort of tort reform, this 250 cap on noneconomic damages should be left up to the States; that the Federal Government shouldn't be meddling. Let me close by asking your thoughts. Is this an appropriate bill for Congress to be considering?

Dr. PALMISANO. Yes, sir, we believe it is. We believe that it affects Medicare beneficiaries. It affects the major health programs

that I mentioned earlier, and we know that there is a crisis in 18 States now. And some States have not been able to make changes, and we are concerned about access to care for patients. So we believe it is a Federal question.

Mr. SMITH. Thank you, Mr. Keller. The gentleman from New York, Mr. Nadler, is recognized for his questions.

Mr. NADLER. Thank you. Thank you, Mr. Chairman. I think it was Dr. Palmisano—you were testifying or answering the questions of the gentleman from California a few moments ago about noneconomic damages. You testified that under this bill, it would not preempt—that the bill, the limit of $250,000 for pain and suffering for noneconomic damages would not preempt State laws that were more permissive; is that correct?

Dr. PALMISANO. That is correct.

Mr. NADLER. So if a State now—traditionally State laws leave it up to the jury and the courts and have no dollar limit in the bill or in the law. Is it your testimony that this would—that that would prevail over the $250,000 limit in this bill?

Dr. PALMISANO. No. The intent of my statement is that if there is no—if there is a cap, then that cap would prevail in that particular State.

Mr. NADLER. If there is a specific money cap listed in the law.

Dr. PALMISANO. Yes. If there is no cap, then this would become the level.

Mr. NADLER. Okay. Thank you. Let me ask you the following: A number of studies have shown over the years—I particularly remember the Harvard study when I was in the New York Legislature in 1985 and we put some rather, I don't remember what they were, but major changes in the law at that time. They were supposed to keep malpractice rates down. And we also ordered a study by Harvard which turned out to say that the major problem, or a major problem, was that a very small proportion of doctors unpoliced by any discipline system were causing a very large proportion of the awards, and that the premiums were high because this very small number of doctors were not properly disciplined.

This morning, in this morning's New York Times, Dr. Sidney Wolfe of the Public Citizen Health Research Group brings up some more modern statistics. He says from 1990 to 2002, 5 percent of doctors were involved in 54 percent of the payouts, including jury awards and out-of-court settlements, according to the National Practitioner Data Bank of the Department of HHS. Of the 35,000 doctors with two or more payouts during that period, only 8 percent were disciplined by State medical boards in any way. Of the 2,800—27,744 doctors who have made payments in five or more cases, five or more judgments or settlements in which they had to make payments, only 463, or less than about 20 percent, 1 out of 6, less than 20 percent had been disciplined.

Would you comment on the assertion, the finding of the Harvard study, the assertion currently that one of the major problems—one of the major jobs, real causes, of what we all agree are high medical insurance premium rates are the failures of the States or the medical societies perhaps to crack down on the relatively small numbers of doctors who perhaps shouldn't be practicing?

Dr. PALMISANO. Well, Mr. Nadler, first off, the American Medical Association supports strong State medical boards, and we know that any payments paid on behalf of a doctor goes before the State medical board. The National Practitioner Data Bank, the problem with the data—and the Government Accounting Office when they studied the National Practitioner Data Bank pointed this out—is that a physician can be listed as having multiple claims, when in reality the physician—it may only be one incident. And so if different—if different entities such as an excess carrier pays on behalf of the physician, that gets counted as a claim. If the primary carrier pays some money or if the physician also has to pay some money, that will all get counted as a claim.

Mr. NADLER. As a separate claim.

Dr. PALMISANO. It gets counted.

Mr. NADLER. And there is no way of culling the data to see how many actual claims there were.

Dr. PALMISANO. That is what the Government Accounting Office criticized the National Practitioner Data Bank. The other thing, sir, about that is that it doesn't differentiate. It doesn't list the specialties. We were very much interested when we heard about that. We wanted to find out who these individuals were, their specialties and so on. And we know, for instance, in south Florida, a recent study done in South Florida points out that every neurosurgeon has been sued in this study and the average number of suits against neurosurgeons is five in south Florida.

And so we certainly——

Mr. NADLER. But that is not the average number of payouts.

Dr. PALMISANO. No, sir. No, an average number of suits. And we know in the Harvard study that you mentioned, that one of the lead authors, Dr. Troy Brennan, a very respected researcher at Harvard, Dr. Brennan wrote in that study that what they found in that study, that there was no statistical correlation with payment, either as a result of a jury award or the insurance company, and negligence. What they did find a direct correlation with was disability. And I had the privilege to be on a panel, a roundtable Secretary Thompson called a couple of months ago, and Dr. Brennan was on the panel with me. And I asked him if he still agreed, believed that; and he said yes, he did.

Mr. NADLER. All right. Let me, before my time runs out, ask you one more quick question because this goes to the heart of this.

Mr. SMITH. Mr. Nadler. Without objection, the gentleman is recognized for an additional minute.

Mr. NADLER. Thank you, sir. Thank you, Mr. Chairman. We have any number of statements here which I am not going to read for interest of time, by all kinds of insurance companies, saying that tort reform that specifically limits noneconomic damages would not result in lower—that they could not promise lower rates, they could not promise that rates wouldn't go up as fast as otherwise. The bill does not require any accountability by insurance companies, and in fact we know that the truly severe cases where there are large noneconomic damages are a small percentage of all claims and the medical liability premium dollar that pays the compensation is dwarfed by the portion that pays for a lot of other things.

Given this, why are you so certain that even if we were to—that a limit on noneconomic damages would in fact result in a solution or any major part of a solution to the premium problem?

Dr. PALMISANO. Thank you, Mr. Nadler. The reason we believe that is we have observed a quarter of a century of history, looking at California, looking at my State of Louisiana, and looking at Wisconsin, looking at Indiana, and looking at New Mexico, and that is exactly what happened. In 1975 California was among the highest. If you went to Los Angeles as an obstetrician or you went to Miami as an obstetrician, what happened was over these 25, 27 years, now they are paying $210,000 in south Florida and the obstetricians in Los Angeles will pay anywhere from 57 to 60 or $70,000 per premium. So we believe it works. It certainly worked in our case in Louisiana. Once the law was passed, my premiums—I didn't have to carry excess insurance anymore. My premiums dropped in half.

Mr. SMITH. Thank you, Mr. Nadler.

The gentleman from North Carolina, Mr. Coble, is recognized for his questions.

Mr. COBLE. Thank you, Mr. Chairman. Thank the witnesses. Mr. Chairman, last Congress I voted for this med/mal bill in Committee because I felt like it deserved full House floor attention. When it came to the House floor, you may recall, I voted against it because I have problems with legislatures imposing caps. I believe when we insert legislative oars into those waters, we are invading waters that ought to be more or less exclusively reserved for juries. That is my philosophical hang-up.

Now, am I not concerned? You bet I am. When I see that specialists are forced to terminate their practices, as you pointed out at the outset, Mr. Chairman, that results in a crisis and that does bother me. I am also informed by the coalition supporting the bill that most of the malpractice cases are either dismissed or settled prior to trial. Well, even if that is the case, I recognize that defendants incur costs even if it never goes to a jury.

But Dr. Palmisano, if you know, of those that are finally litigated and jury awards are forthcoming, do you have any idea what the average jury award would be? And if you don't, you can get back to us.

Dr. PALMISANO. We will be glad to supply any data we have, but I believe Mr. Smarr has some figures that would answer that.

Mr. COBLE. Mr. Smarr, do you have that?

Mr. SMARR. Yes, sir, I do. The mean verdict against an individual practitioner——

Mr. COBLE. Oh, you may have said that earlier but repeat it for me, if you will.

Mr. SMARR. It is $496,726 in 2001, and there is usually more than one defendant in any case.

Mr. COBLE. Mrs. Keller, the physician you mentioned in your testimony, does she continue to practice medicine?

Ms. KELLER. Yes, sir, she does. With more malpractice lawsuits filed this year against the same doctor.

Mr. COBLE. In what State does she practice?

Ms. KELLER. Georgia.

Mr. COBLE. Dr. Palmisano, you indicated that the crisis States—have been 8 or 10 additional States added to that list if I am not mistaken in recent days, in fact, and the total is now how many?

Dr. PALMISANO. It is 18, sir. Six additional States were added. We will be glad to leave a map with the Committee.

Mr. COBLE. Yeah. In fact I am familiar with that.

Dr. PALMISANO. Yes, sir.

Mr. COBLE. And even though, folks, I have problems with the capping and I hope you all understand that, I just think that ought to be a jury question. Not to say that I am uncaring or insensitive, Mrs. Dyess, for example, about your situation. My gosh, you and Mrs. Keller have brought compelling arguments that support either side of this issue. And if there was ever an issue before us, Mr. Chairman, that invites compelling arguments supporting each side, I think it is the matter that we have before us today, and I very much appreciate you all being here.

Mr. Chairman, I appreciate the very precise manner in which you are conducting this hearing and I yield back my time before the red light appears.

Mr. SMITH. It is much appreciated, Mr. Coble. Thank you.

The gentleman from Virginia, Mr. Scott, is recognized for his questions.

Mr. SCOTT. Thank you, Mr. Chairman.

Mr. Smarr, what portion of your income is investment income as opposed to the difference between the premium and the expected payments?

Mr. SMARR. In 2001, the insurers that I represent collected 31 cents for every dollar in investment income for every dollar of premium which they collected. They incurred losses in the neighborhood of, and I—it is in my written testimony, actually.

Mr. SCOTT. Well let me—you said $1.53 for every dollar you collected in premium. Are those the numbers you said?

Mr. SMARR. That is for the industry as a whole, yes. That includes the commercial carriers.

Mr. SCOTT. Now, were you making money doing that?

Mr. SMARR. Absolutely not.

Mr. SCOTT. How long were you charging only—how long were you charging only a dollar for $1.53 in premiums in payouts?

Mr. SMARR. How long?

Mr. SCOTT. Yes.

Mr. SMARR. That statistic is called the "combined ratio," and we have seen that deteriorate over the past 4 or 5 years. The industry turned to negative profitability last year.

Mr. SCOTT. I mean you make—I mean you can collect less than you pay out and still make money, isn't that right?

Mr. SMARR. Because we have investment income; that is correct.

Mr. SCOTT. Okay. And you are collecting, knowing you were collecting a dollar for $1.53 in expenses, you are going to make up the rest in investments; isn't that right?

Mr. SMARR. That is the intent, yes.

Mr. SCOTT. Okay. Now you mentioned 6.9 percent inflation.

Mr. SMARR. The average cost of a paid claim is going up by 6.9 percent per year.

Mr. SCOTT. And you compared that to the Consumer Price Index.

Mr. SMARR. 2.6 percent.

Mr. SCOTT. Did you compare it to the Health Consumer Price Index?

Mr. SMARR. No, I did not.

Mr. SCOTT. Wouldn't that be a more accurate figure to compare it to?

Mr. SMARR. I don't believe it would, sir.

Mr. SCOTT. Okay. On the collateral source rule, if a wrongdoer has created the problems, the plaintiff has paid a premium for the benefit of insurance. Why shouldn't either the plaintiff get benefit for that payment or at least get a lower premium because Blue Cross/Blue Shield will get their money back?

Mr. SMARR. In health insurance, claims are paid relatively soon after the incident, if you will, occurs. Oftentimes they are paid within—well, we would hope within a week or a month or within the same year. It takes over 5 years to conclude a medical malpractice case after the time of the incident. And the various flows of cash to pay for the premiums actually through the market, adjust themselves to accommodate the true costs of the insurance.

Mr. SCOTT. So you are saying that the wrongdoer ought to get benefit from the plaintiffs—two equal plaintiffs, one with health insurance and one without, the benefit of the health insurance ought to go to the wrongdoer and not to the plaintiff, or Blue Cross/Blue Shield getting the money back?

Mr. SMARR. No, sir I am not; I don't look at it in——

Mr. SCOTT. Under this bill, who gets the benefit of the insurance? The wrongdoer, isn't that right?

Mr. SMARR. The wrongdoer pays for the insurance.

Mr. SCOTT. No, the wrongdoer, if there is a—if you caused a million dollars' worth of damage and the plaintiff has a million dollars' worth of health insurance, who gets the benefit of the health insurance? There are three possibilities. One, the wrongdoer gets the benefit. Two, the plaintiff gets the benefit. And third, Blue Cross/Blue Shield can get their money back after the wrongdoer has paid. Your idea is that the wrongdoer should get the benefit.

Mrs. Keller, can you state with specificity what portion of your damages were caused by the physician, the hospital, the hospital personnel and the ambulance personnel?

Ms. KELLER. Well——

Mr. SCOTT. I guess not. That would be an impossible burden for you to fulfill, wouldn't it.

Ms. KELLER. Correct. There is no—however, I cannot legally hold the ambulance liable even though I was given the bill to pay.

Mr. SCOTT. And if everybody pointed at the ambulance as the cause for your problem, you wouldn't know one way or the other.

Ms. KELLER. Exactly. I also cannot——

Mr. SCOTT. Wait a minute. Mr. Smarr, can you explain what the rationale is to force the plaintiff to go all over to figure out who did what and have a separate duty of care, violation of duty of care, and proximate cause for each of what in her case could be any number of different persons?

May I ask for 1 additional minute, Mr. Chairman.

Mr. SMITH. The gentleman from Virginia is recognized for an additional minute.

Mr. SMARR. I am not a lawyer but it is my understanding that the courts routinely do apportion fault.

Mr. SCOTT. Now, on a joint and several, and you know this—on a joint and several, if you get one of them good, they are responsible for the full damage. And if they want to get contribution then they go chasing after everybody on their dime, not on the plaintiff's dime. Can you explain to me what the rationale is to force the plaintiff, who doesn't know—all they know is they went in and an operation was botched. Why is it their responsibility to apportion how much of it was the anesthesiologist, how much of it was the surgeon, how much of it was the nurse; having to call in extra witnesses to prove each and every step of the way, and if they miss 5 percent, then all the rest just pay 95 percent? What is the purpose of that?

Mr. SMARR. Well, first of all, plaintiff attorneys normally name many defendants in a case, many who were not even involved in the case sometimes. Secondly, it is not the plaintiff's responsibility to apportion fault. That is the duty of the court. The court does that.

Mr. SCOTT. Well the court does it based on the evidence. Mr. Chairman, the witness is not being——

Mr. SMITH. Mr. Scott——

Mr. SCOTT. Can I make——

Mr. SMITH. I think the witness has done the best he can to answer the question. But the gentleman is recognized for one last question.

Mr. SCOTT. He did the best he could because he didn't want to answer the question.

The court makes the decision based on the evidence that is presented. If no evidence is presented then the plaintiff, with the burden of proof, loses. And if you have got 5 percent over here and 10 percent over there and 8 percent over here, and if you don't prove the 3 percent over there, then you lose on the 3 percent. If everybody is pointing to an empty chair or a bankrupt or uninsured person, then the plaintiff will lose that little 3 or 5 percent. The normal law is under joint and several, and this is how you apportion insurance anyway—if you get one you have got them all. And if they want contribution then they go chasing after everybody. But you put that burden where the plaintiff doesn't know anything about what happened. Isn't that an unfair claim?

Mr. SMARR. I don't understand. If somebody is not responsible, then why should they have to pay?

Mr. SCOTT. If they are not responsible, they don't have to pay at all.

Mr. SMARR. I believe that is true, yes.

Mr. SMITH. And, Mr. Scott, the gentleman's time has expired.

Mr. SCOTT. But they don't have to apportion it.

Mr. SMITH. The gentleman from Ohio, Mr. Chabot, is recognized for his questions.

Mr. CHABOT. Thank you, Mr. Chairman. I think we all appreciate you holding this very important hearing on a topic that is clearly timely.

While the issues of rising health care cost and dramatic increases in medical malpractice rates are a national problem, families in my

district back in Cincinnati, they have been especially hard hit by this crisis. I have spoken with dozens of families who are not only facing large increases in their insurance premiums, but who are finding it increasingly difficult to find specialists to treat their families. I have also met with many doctors in my district and they are extremely concerned about the rising cost of medical malpractice insurance and the potential long-term effects on patient care.

Excessive medical liability costs have had a serious impact on the health care system in Cincinnati. Medical malpractice insurance rates have skyrocketed in recent years and patients are paying the price, unfortunately. And insurance costs rise to astronomical levels. Health care providers have been forced to pass those costs on to their patients and cut back on services and even taken the drastic step in many instances of closing their practices. And I have had a number of doctors that have told me that is what they have had to do as a result of this.

Today Dr. Palmisano has testified that patient access to care had reached the crisis level in Ohio and in 17 additional States, due to unrestrained medical malpractice litigation. According to the October 2002 Medical Liability Monitor, Ohio ranked among the top five States for premium increases.

In Cincinnati, in my district, physician groups have experienced premium increases between 20 and 100 percent in recent years. But Cincinnati is not the only community confronting this issue, as we know. This rising cost of medical liability insurance is a growing national problem and it requires a national solution, and that is why we are here today.

Just a couple of questions. Dr. Palmisano, and Mr. Smarr, you had a chart up here before, "America's Medical Liability Crisis: A National View." I wonder if somebody could put that chart back up for a moment. The white States which are at this point currently okay according to the chart. Now obviously, California is one in which the reform has already been under—in effect for 25 years now. Could you touch on the other States. Are there any similarities? Why the other States; Colorado, New Mexico, Louisiana, Wisconsin and Indiana also seem to be in better shape than the other States?

Dr. PALMISANO. Yes, sir. Those are all States with caps. My State of Louisiana is a State that passed a cap in 1975. It is a total cap on damages, but future medicals as incurred vary similar to New Mexico's law. Colorado has a cap on noneconomic damages. Indiana has a total cap and Wisconsin has a cap on noneconomic damages.

Mr. CHABOT. Okay. Do any of the other States that are either in trouble, or the yellow States which it says they are showing problem signs but aren't necessarily in crisis like the red States, have any of those enacted any caps?

Dr. PALMISANO. Yes, sir, they have. Some of the States, for instance, Missouri, which has now become a crisis State, it has a cap. But the cap is a cap per individual, per claimant. So you could have multiple caps in one case. Nevada, which closed its level one trauma center on July 3, 2000 for 10 days, it went into special session and passed a cap but its cap is also per claimant and per doctor. So what we have found is that the caps that are fixed caps per incident are the ones that have resulted in stability.

Mr. CHABOT. Okay, thank you. Could you identify which physician specialties are most affected by the medical malpractice crisis that we are discussing today and why those particular areas would be in difficulty?

Dr. PALMISANO. Yes, sir. The obstetricians, the neurosurgeons, the emergency physicians, because these are the ones that—the physicians who are involved with complicated procedures, with more risky cases, and the outcome sometimes is not the—is not a complete cure. The neurologically impaired newborn, for instance, can—if a baby is born with neurological impairments there can be multiple suits filed as a result of babies being born that way.

A recent study by the American—ACOG, the obstetricians, gynecologists, and the pediatricians, their recent studies show that the majority of these had nothing to do with events surrounding the birth of the child, but were for other reasons, in utero, when the baby was in the uterus.

Mr. CHABOT. Thank you. Mr. Chairman, I ask unanimous consent for 1 additional minute.

Mr. SMITH. Without objection, the gentleman from Ohio is recognized for an additional minute.

Mr. CHABOT. Thank you. Opponents of the HEALTH Act have claimed that capping noneconomic damages prevents patients from adequately recovering from their injuries. And as you have already discussed to some degree, there are still clearly some things which are not capped which there are no limits on. Would you discuss briefly, again, what you can recover for and where there are no limits?

Dr. PALMISANO. The only limit on the damages in H.R. 5 is the noneconomic damages, the ones that can't be quantified.

Mr. CHABOT. You are talking about pain and suffering.

Dr. PALMISANO. Pain and suffering-type damages. But certainly all medical costs, all rehabilitation, child care, and anything that can be economically documented. And I think Chairman Smith has pointed out cases in California where multiple millions of dollars have been awarded to an individual for the rehabilitation, medical expenses, and so on.

Mr. CHABOT. Thank you very much.

Mr. SMITH. Thank you, Mr. Chabot. The gentlewoman from Texas, Ms. Jackson Lee, is recognized for her questions.

Ms. JACKSON LEE. Thank you very much, Mr. Chairman. I appreciate all of the witnesses' testimony this morning because this is an extremely painful process, particularly for the victims that are here. And certainly, Dr. Palmisano, I appreciate very much the concerns that physicians have. I interact extensively with my local medical community and realize the importance of having physicians based in the community, in the neighborhoods. And representing a particularly poor district in this Nation, we face the crisis of health care every day. And so I know this is an important hearing.

Let me start with Mrs. Keller, and I want to thank you very much. I am not sure if that is a picture of you behind you. Maybe I need to put on—it is not yours. Thank you very much. I see that. But let me just raise this point with Mrs. Keller. As I understand it, you had initially a botched surgery that caused you to be in the

doctor's office, and you were being examined. Is that correct? You were in the doctor's office?

Ms. KELLER. Yes, I was in the doctor's office. Whether or not the surgery itself was botched would be argumentative. No sutures were used underneath the layers, which is no longer substandard of care.

Ms. JACKSON LEE. So you were in there for an examination; is that correct? You were in there for an examination?

Ms. KELLER. No, ma'am. I was—the initial surgery, they did not use complete and total suturing procedures, which is what caused my wound adhesion there in the office a week later.

Ms. JACKSON LEE. Okay. And so you were inside an examining room. That is what I am trying to understand.

Ms. KELLER. Yes, ma'am.

Ms. JACKSON LEE. And then you lost consciousness and you fell.

Ms. KELLER. Yes, ma'am.

Ms. JACKSON LEE. Okay. The reason why I wanted to just get that clear is I wanted to sort of track the scenario. With that in mind, let me sort of call the roll of the many people that might be involved. I am not in any way suggesting that we have all these names, but the doctor whose examining room you were in, the nurses, the hospitals, and the surgical individuals who may have done the surgery, the nurses, as I said in the doctor's office, the ambulances, the ambulance drivers, the emergency room staff, physicians and doctors. Ultimately there is a long list that may have had some impact on your present condition.

Ms. KELLER. Exactly.

Ms. JACKSON LEE. During part of that time you were in great pain and during part of that time you were unconscious; is that correct.

Ms. KELLER. Correct.

Ms. JACKSON LEE. So part of the legislation that we are now talking about would require you to have been at the fullest peak of your health, to have a notepad, taking notes, maybe even a camera, taking pictures through the entire process of this terrible tragedy that has befallen you; is that correct? Would that have had to be the case for you to be knowledgeable about who you would point the finger at if this legislation we are now having a hearing about would pass?

Ms. KELLER. Precisely.

Ms. JACKSON LEE. And let me offer to you my appreciation for your courage for being here. I want to cite for the record, Mr. Chairman, my State, the State of Texas, approximately 3 to 7,000 preventable deaths in Texas each year due to medical errors. The preventable medical errors in Texas cost between 1.3 billion to 2.2 billion. Medical malpractice insurance is 421.2 million. And we have found that medical malpractice claims have dropped in the last 2 consecutive years.

At the same time, we find that Texas is 49 in the quality of care. We find that Louisiana is 51, and California is 44. So it is interesting to note that States that have had an impact by medical malpractice changes or law changes are still at the bottom of the totem pole in terms of access to medical care or quality of care. And Texas, of course, remains at the bottom of the totem pole as well.

My question, then, is to Dr. Palmisano, to simply ask this one question. If, through the devices of the insurance companies, they could devise an investment formula or a pricing formula that would eliminate or bring down the costs of premiums across the Nation, would that be acceptable to the American Medical Association?

Dr. PALMISANO. Well, thank you for the question. The American Medical Association wants to make sure that patients have physicians, and so it is the escalating rates that cause us problems. We also are concerned about the number of cases that are filed.

Ms. JACKSON LEE. Doctor, you are not answering my question. If the insurance companies devise a formula that would bring down the rates, would that be acceptable to the American Medical Association?

Dr. PALMISANO. If they were reasonable rates and we didn't have a crisis, then the American Medical Association wouldn't be here today.

Ms. JACKSON LEE. Thank you. Mr. Chairman——

Mr. SMITH. Thank you, Ms. Jackson Lee. The gentleman from Virginia, Mr. Goodlatte, is recognized for his questions.

Mr. GOODLATTE. Thank you, Mr. Chairman.

Gentlemen, I support this legislation because I believe that the caps are effective. I think the evidence points to that. We have a different type of a cap in Virginia and I think it has had some effect in Virginia, and I like the fact that that legislation provides some flexibility to the States to adjust the amount of the cap on noneconomic losses. But I am concerned that I don't think this legislation does a great deal to screen out the most frivolous and fraudulent lawsuits.

If you open up the Yellow Pages here in Washington or any other city in the country, you will see ad after ad after ad and they have one common theme: It says, "No fee if no recovery" meaning, no risk to you. So, you know, if you think you have got a case, go ahead and take it. Now, the attorney has got to impose some screening because they are not going to want to take a lot of cases in which they get no recovery. However, given the pressures that are on insurance companies to settle these cases and given the fact that physicians hate to have cases settled that are essentially harmful to their reputation if they don't believe that any real malpractice has occurred, why isn't there something in this legislation to penalize those who bring truly frivolous or fraudulent lawsuits?

Right now in our Federal courts and I imagine in many State courts that mirror the rule 11 sanctions in Federal courts, those are very weak, they are very rarely applied, and why aren't there some greater sanctions in here; for example, some form of a loser-pays type of mechanism imposed upon those who bring frivolous cases that would encourage insurance companies, encourage doctors to be able to defend their case and if they win, recover some attorneys' fees and know that because of that risk, attorneys on the other side are going to be even more diligent in screening out those cases that have no merit?

Dr. Palmisano.

Dr. PALMISANO. Thank you, sir. Well, certainly, the American Medical Association has policy regarding loser pays. It is not in this particular bill but we will be glad to submit to the Committee our

policy on loser pays. We have policy on medical—I will read it to you just briefly.

"Implementation of the Loser-Pays Rule in Medical Liability Litigation. Responsibility for prevailing party's legal expenses including attorneys' fees should not be shifted to a losing party in medical liability litigation unless (a), some provision is made for retrieving fees owed to a prevailing party from the losing party's attorney in the event the losing party has no available assets; (b), some provision is made to calculate fees owed to a plaintiff's attorney on the basis of a reasonable value of time expended regardless of the existence of a contingency fee arrangement."

Mr. GOODLATTE. I would love to have a copy of that and I would suggest to you that the modified loser-pays provision that this Committee has passed out attached to other legislation, Y2K liabilities and tort reform passed during the Contract With America, would meet those criteria. And I would commend to you an examination of that, because I think that is a weakness in this matter.

The second thing that concerns me about this is on the other hand, I am not a strong believer in the Government stepping in and with regard to an individual's right to contract with somebody else, to interfere with that. And this bill does put caps on attorneys' fees. Every case is different and the merit of whether or not a particular case should be taken by an attorney based upon how much work is going to have to go into the case is measured into what kind of a contingent fee they will charge. And when you start capping that, you are, in my opinion, being unfair.

Now, I understand that the reason for doing that, at least one of the reasons is that you are in effect having the opportunity to reduce your overall costs if the overall amount of money that is paid out by insurance companies is reduced. But the same—the same standard applies, it seems to me to defense attorneys. Why aren't we capping that? So in my opinion, I would not cap defense attorneys' fees. I would also not cap plaintiffs' attorneys' fees, and I think that is a provision in here that I would prefer not to see.

And I would welcome Mr. Smarr or Dr. Palmisano's response to that.

Mr. SMARR. Well, insurers try their best, I can assure you, to cap defense attorneys' fees. In fact, we pay very close attention to that. The plaintiff attorney fees in this bill are capped on a sliding scale such that the smaller amounts of indemnity amounts that might be paid, the plaintiff attorney gets a larger percentage of it. But even so, in a million dollar case, the plaintiff attorney still gets $220,000 in fees.

Mr. GOODLATTE. But, Mr. Smarr, there are million-dollars' cases and there are million-dollars' case. One might be a very open-and-shut type of case where you might think the attorney has been unjustly enriched with their fee, and there might be another million-dollar where it is $900,000 worth of economic loss, and the fact of the matter is that that attorney had to go to tremendous additional efforts to prove the case and to bring in a multitude of witnesses. There might be a multiple number of defendants in the case. And you are arbitrarily setting that fee based simply on the dollar amount in the case without recognizing the fact that there is different amounts of work in different cases; just like the defense at-

torney who in an open-and-shut million-dollar case will probably submit a small bill because the attorney didn't spend a lot of time on it, but another million-dollar case, the attorney might have a very substantial bill because a tremendous amount of time was put into it.

Mr. SMARR. I agree that there can be outliers, as you are describing. But I think the legislation is intended to treat the majority of cases that come forward in some rational manner, and this system has worked well in California for over 25 years.

Mr. SMITH. Thank you Mr. Goodlatte.

The gentleman from Massachusetts, Mr. Delahunt, is recognized for his questions.

Mr. DELAHUNT. Mr. Smarr, how do you feel about capping CEOs' salaries? You wouldn't.

Mr. SMARR. I don't think that would apply here.

Mr. DELAHUNT. Okay. I see it doesn't apply in this case. This legislation also benefits HMOs; is that correct? Mr. Smarr.

Mr. SMARR. Would you say that again, sir?

Mr. DELAHUNT. This particular proposal before us benefits HMOs; is that correct?

Mr. SMARR. To the extent that they are included in the malpractice claim, yes.

Mr. DELAHUNT. Thank you. There have been crises in the past, haven't there, in the mid-1970's and the mid-1980's?

Mr. SMARR. There have been periods where we have seen more rapid escalation of multi——

Mr. DELAHUNT. Let's call them crises. Would you agree with me there have been crises in the past.

Mr. SMARR. Not to the extent we are seeing today. But if you wish, yes.

Mr. DELAHUNT. Okay. Is part of the problem the fact—and you are correct in your statement in terms of percentage of bond holdings that various insurers and insurance companies hold, the interest rates have gone down.

Mr. SMARR. That is true.

Mr. DELAHUNT. And is that a significant piece of the problem?

Mr. SMARR. It is a piece of the problem, but at the same time bond values have gone up.

Mr. DELAHUNT. All right. I understand bond values, but in terms of the flow of cash and income, you know when we are getting 1, 1½ percent as opposed to 6 or 7 percent, it creates a significant cash flow problem.

Mr. SMARR. We are getting 4 to 5 percent instead of 7.

Mr. DELAHUNT. I want to know where you are getting that 4 or 5 percent and I will change my portfolio accordingly.

Mr. SMARR. Long-term corporate bonds.

Mr. DELAHUNT. Okay. But, again, those long-term corporate bonds, presumably 4 or 5 years ago you'd be getting 9 or 10 percent. What I am saying is that you know there is great disagreement in terms of what is causing this particular spike. But there have been crises in the past and we have worked our way out of them.

Let me ask you this. Your association, PIAA, is it a for-profit organization, or—you said it is owned by physicians and other stakeholders in the health care system.

Mr. SMARR. The PIAA is an association, is a 501(c)(6) nonprofit. The insurance company members are insurance companies, for-profit companies.

Mr. DELAHUNT. Okay. And those insurance companies were for profit. To a large degree, they are owned by physicians and other health care providers.

Mr. SMARR. Correct.

Mr. DELAHUNT. So they are making a profit obviously on the return of their investment.

Mr. SMARR. Yes, sir. It is necessary that they make a profit. Especially——

Mr. DELAHUNT. Okay. Thank you. That is all, I just wanted to know.

Why 250,000? How was that calculated in terms of a cap?

Mr. SMARR. Two hundred fifty thousand is the cap, as you know, that was enacted in California.

Mr. DELAHUNT. But wasn't that enacted back in 1975?

Mr. SMARR. Yes, it was.

Mr. DELAHUNT. Okay. That is all. I am just—I just want to continue because, again, we don't have too much time. I have seen various studies, and maybe you could help me with this, that indicate that deaths as a result of medical malpractice vary from 48,000 annually to 98,000 annually. Which is the right figure? Mr. Smarr.

Mr. SMARR. Well, the 98,000 figure comes from an extrapolation of data of the Harvard medical practice study. In that study, 171 people were determined to have died partially because of——

Mr. DELAHUNT. Which figure do you accept?

Mr. SMARR. I don't accept either one of them, sir.

Mr. DELAHUNT. You don't?

Mr. SMARR. No. There is some number. I agree that there is some number, but I don't accept——

Mr. DELAHUNT. Is it closer to 48,000 or closer to 98,000?

Mr. SMARR. I do not know.

Mr. DELAHUNT. You don't know. Okay. In terms of confidentiality agreements, I understand most of these settlements that are made are subject to a confidentiality agreement. Would you have any objection to an amendment to the bill that would allow confidentiality agreements be at the discretion or at the option of the patient?

Mr. SMARR. I can't comment on that because I am just not aware of the nature of those agreements.

Mr. DELAHUNT. Okay. And the statute of limitations, why 3 years? What if—let me give you a hypothetical. What if, for example, the injury is not discovered during the course of a 3-year period?

Mr. SMARR. It's my understanding it is 3 years from the time the injury manifests itself.

Mr. DELAHUNT. No, you are wrong. It is from the time the injury occurred. Would you be willing to change that, 3 years from the date that the injury manifests itself?

Mr. SMARR. I would have to go and look at the legislation, sir.

Mr. DELAHUNT. Okay. I just have one final question if I may. If 1 year after you found out—and, Mrs. Dyess, I know, believe me.

Mr. SMITH. Will the gentleman from Massachusetts yield and I will read to him from the legislation?

Mr. DELAHUNT. I—what I would like to do is have an additional minute because I know my questions, and I just want to——

Mr. SMITH. Let me read from the legislation and I will be happy to grant you an additional minute.

Mr. DELAHUNT. Thank you.

Mr. SMITH. The time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after claimant discovers, or, through the use of reasonable diligence, should have discovered the injury.

Now the gentleman is granted an additional minute.

Mr. DELAHUNT. Well, I thank my friend, the Chairman. I really—and I know we all sympathize with what you are saying, and it really is a problem that has to be addressed in terms of access to health care. I recently met a woman who had a son; his name, Steve Olsen. He is a 12-year-old from San Diego who is blind and brain damaged because of medical negligence. It was proven. When he was 2 years old, he fell on a stick in the woods. Steve's doctor gave Steve steroids and sent him home. Although his parents asked for a CAT scan, the doctor refused. The following day Steve returned to the hospital in a coma because of the growing brain abscess he had developed which would have been detected had the CAT scan been performed. At trial, the jury concluded that the doctor had committed medical malpractice and awarded $7.1 million in noneconomic damages. Remember, this is a 12-year-old. One of the jurors later explained that they saw Steve as a boy doomed to a life of darkness, loneliness, and pain. He would never play sports, work, or enjoy normal relationships with his peers. He would have to endure a lifetime of treatment, therapy, prosthesis fitting, and around-the-clock supervision. The judge, however, was forced to reduce that damage award to $250,000 because of the cap in California. What do you say to that mother? What do we say to that mother?

Ms. DYESS. Do we ever hear about the good cases? Do we ever hear anything good about what doctors do? No, we are here to hear all the bad. We never hear about the good.

Mr. DELAHUNT. No, I am not here to bash or criticize doctors. And I even think Mrs. Keller in her testimony indicated that it was her neurosurgeon who worked a miracle. But this is about—it is not about doctors. It is not about lawyers. It is not about anything. And it ought to be about potential victims and patients like your husband.

I yield back.

Mr. SMITH. Thank you, Mr. Delahunt. The gentlewoman from Pennsylvania, Ms. Hart, is recognized for her questions.

Ms. HART. Thank you, Mr. Chairman.

Mr. Smarr, you noted in your testimony that 61 percent of medical malpractice claims are dropped or dismissed. Do you find that this is typical across the spectrum of tort claims in all different States? I am interested especially in Pennsylvania which is my home. Our insurance rates in Pennsylvania have increased over

125 percent over the last 4 years. Have the dropped or dismissed cases impacted our rate jump differently and is that a number that changes from State to State?

Mr. SMARR. It is a number that varies slightly from State to State. I spent 13 years working in the Pennsylvania market and the numbers there are very similar.

Ms. HART. Do you think that the dropped or dismissal rate is different in States, you know, some of the like white States, for example?

Mr. SMARR. I don't know. I would have to find out.

Ms. HART. I would be interested in knowing that.

Mr. SMARR. I can get that for you.

Ms. HART. If you could possibly find that out for us.

Ms. HART. Okay. Dr. Palmisano, I happen to be a graduate of a liberal arts college and as a result have a lot of friends who practice medicine now. They are all in pretty much a good spot in their careers, beginning to take over and beginning their own practices. One of my best friends is an OB-GYN who told me in November that she was going to cease practicing by the end of the year because she had lost insurance coverage and didn't see any hope of being able to regain it. Aside from that problem—fortunately she found insurance at the very last minute and is still practicing, but at a much higher rate. Eighty percent of the doctors in Pennsylvania, according to the Pennsylvania Medical Society, say they can't even recruit new physicians for their practices. Do you see that trend in other States? Is it more acute in the red States such as mine?

Dr. PALMISANO. Yes, Ms. Hart. We see that in the States that are designated as red States in crisis. In Wheeling, West Virginia, for instance when I visited there and I met with the family practice residents, every one that I—they brought the whole residency crew to meet me and every one of them said that they were not going to stay in West Virginia because of the liability situation. They were going to go somewhere where it was more stable.

Ms. HART. Okay. Then, as far as this issue—and you say it is actually reaching pretty deeply into health care provision. Do you find—and it seems to me, from what I have heard about Pennsylvania, for example, the Uniontown Hospital, which is in Fayette County, which is a very poor area, now doesn't provide any obstetric services. It seems that health care for the poor has actually been made significantly worse by this crisis. Do you see that happening in other regions across the country? Is it adversely affecting the poor even more?

Dr. PALMISANO. Yes. We find that people who would volunteer to work in clinics are saying that they are unable to do this because of the liability problems and some of these clinics are closing. We have heard people come forward and say that they wouldn't be able to continue their services because of the liability for the clinic. We have had physicians come and give statements regarding volunteer work that they wanted to do as retired physicians and go into areas where they could help, where there was no available physicians in that area, that they are—because of the liability climate they are unable to do that, and they want to do that. So there are

a number of people that are willing to do that but they are just concerned about the liability system.

Ms. HART. I read recently in that vein, a story of a physician who had wanted to volunteer, had been consistently volunteering like 6 months at a time on Indian reservations providing medical services, and just recently, just couldn't do it because of the liability costs.

I have one quick final question, and that is—actually I think probably both Mr. Palmisano and Mr. Smarr—regarding the claim that California's success in this area is not really due to MICRA but due to Prop 103. Do either of you have a comment on that?

Mr. SMARR. Yes, I do. Prop 103, as I testified earlier, was an auto initiative that also included malpractice insurers. But the crux of this matter is that the malpractice insurers reached agreements with the insurance commissioner, and I have them here and I would like to present them to be included in the record, if you would, that they did not have to roll back their rates. They made a one-time return of premium equal to 20 percent of annual premium to be paid as a dividend. This happened at a time when the California malpractice carriers were paying dividends in excess of 20 percent. And so it was a way to break the logjam to get these unintended targets, or nontargets rather, out of the way and to go on and deal with the auto carriers which were the real focus of the issue. So that is—it just didn't have an effect.

Mr. SMITH. Thank you, Ms. Hart.

The gentleman from California, Mr. Schiff, is recognized for his questions.

Mr. SCHIFF. I thank the Chairman and in particular want to thank Mrs. Keller and Mrs. Dyess for coming today and sharing your personal stories with us. I am from California and very familiar with the MICRA law out there, and MICRA did impose $250,000 limits but that was a quarter of a century ago.

Doctor, why wouldn't it be appropriate in this bill to remedy what many in California see as a flaw of the MICRA bill, that MICRA never had a cost-of-living adjustment? Two hundred fifty thousand dollars in California a quarter of a century ago was very different than today. Why not add a COLA to this bill?

Dr. PALMISANO. That question comes up on a number of occasions and what we note is that the California market is stable. It is a proven treatment. We know that the Medical Society of New Jersey wanted some advice on some bills that were introduced in New Jersey and they called in Tilling Haas in the last couple of months, and they said that those particular bills would not lower rates. But, they did comment on caps. They said that a $250,000 fixed cap would stabilize the market and decrease the insurance rates, and they said as you increase the noneconomic cap to the point that when this reaches $500,000 it no longer has any effect. So, that is a recent study done by Tilling Haas.

Mr. SCHIFF. That really doesn't answer my question. If you put a COLA in this bill, then it doesn't get to $500,000 until so many years of cost-of-living increases have gone up. Why not have a cost-of-living adjustment in this? Plainly it would have the same effect on the insurance premiums. It might not be quite as dramatic as without the COLA, but isn't what really is going on here is that

in California there has been an inability to pass a COLA because of the institutional difficulty of really changing anything in this area? And isn't the lack of a COLA in this bill really premised on the same presumption of inaction in Congress, that if we pass this bill with no COLA in it, it will be at least another quarter of a century before a COLA can be provided? What would be unfair about having a cost-of-living adjustment so that this amount is not static over the years?

Dr. PALMISANO. Well, you know, Missouri did—the State of Missouri did pass a cap with—that could increase the cost-of-living. And now they have become—they are now over $500,000 with their cap and now have turned into a red State, a crisis State. Also in H.R. 5——

Mr. SCHIFF. Doctor, is your contemplation, then, that this cap should go on indefinitely at this amount?

Dr. PALMISANO. It depends what the future holds. What we do know it has a flexi-cap provision.

Mr. SCHIFF. Well let me ask you, then, another question. I do think there is a crisis and a problem here. What I want to make sure is that the solution is one that works over time but also addresses the problem. And if I could, Mr. Smarr, the presumption is if we pass this bill, insurance premiums go down, correct?

Mr. SMARR. Correct.

Mr. SCHIFF. Would you be willing to support a sunset provision, that if we pass this bill and, in fact, insurance premiums do not go down, that rather than the difference is merely pocketed by the insurance companies, that the bill will be sunsetted?

Mr. SMARR. I can't speak to that because I am speaking for my organization. I don't know.

Mr. SMITH. Would the gentleman from California yield for a second? A few minutes ago Mr. Smarr testified that they may not go down. They just may not increase as quickly as projected. So you might want to incorporate that into your question. Thank you for yielding.

Mr. SCHIFF. Well, I mean this is really a part of what I am trying to wrestle with, which is are we merely going to be enhancing the bottom line of the insurance firms without doing anything for the patients that are really at the core of this? This seems to be a struggle between the doctors, the lawyers, and the insurance companies. And I am not clear that the outcome is going to really benefit the patients yet, at least from what I have learned thus far.

Let me ask about one other point, Doctor, if I could, on the preemption question. Because after your testimony I went through the bill because I wasn't sure I understood the preemptive impacts. As I read the language of the section now, it provides that State limits on compensatory or punitive damages would be allowed to maintain, unless there were no such limits, whether you passed them before this bill or after this bill. They would continue on and not be preempted. But other than that, and defenses that are available to hospitals or HMOs or health care providers which would also not be preempted, everything else would be preempted. So the rules about statutory limitations in States would be preempted. Fair share rules would be preempted, contingent fees would be preempted, collateral source rule would be preempted.

Mr. SCHIFF. The standard for punitive damages might be preempted; is that your reading? If the bill says that only the amounts will not be preempted, does that mean that this Federal law would change the standard for when punitive damages can be demonstrated in the 50 States, such that if one State felt that to protect its patients, it needed to make it easier for people to prove the punitive damages standard, that that would not be preempted by what we are doing now?

Mr. SMITH. The gentleman is recognized for an additional minute to get an answer to his question.

Dr. PALMISANO. Let me make sure. I will talk to counsel to make sure that I know how to answer this properly.

Thank you for your patience. If there are punitive damages—if there are no punitive damages, for instance, in Louisiana there are no punitive damages unless someone is killed. There are two exceptions, but it has nothing to do with medical malpractice; it has to do with someone who is drunk and kills someone while driving intoxicated.

So it would not give punitive damages in the State of Louisiana. What it would do is, it—if the State had a lesser standard, this would preempt it as far as the punitive damages, the way I understand it.

Mr. SCHIFF. So that while a State could continue to maintain a certain limit on punitive damages, the standard of proof that you would have to meet would be preempted by this bill?

Dr. PALMISANO. If it was lesser.

Mr. SCHIFF. If it was less rigorous. In other words, if California or any other State——

Dr. PALMISANO. If it was a less rigorous State law.

Mr. SCHIFF. So it is not only the naked amounts of the damages that are not preempted, but the level of protection that a State wishes to give in terms of how it defines when punitive damages should be awarded, that would be preempted, as well as all of the other provisions that I mentioned?

Dr. PALMISANO. That is correct, talking to legal counsel, yes.

Mr. SMITH. Thank you.

The gentleman from Michigan, the Ranking Member of the Judiciary Committee, Mr. Conyers, is recognized for his questions.

Mr. CONYERS. Thank you, Mr. Chairman.

I want to thank Mrs. Keller and Mrs. Dyess for being here today. Their testimony was very important. We appreciate you helping us out.

Now, I want to talk to the President-elect of the AMA, who is a renowned jazz aficionado from New Orleans. And I appreciate my earlier talks with him.

But this conversation is about a board of trustees of the American Medical Association, Report 35, that responds to Resolution 212 instructing the board of trustees to make professional liability reform the association's highest priority and to report back to the House of Delegates on the activities initiated.

And here is the part that we have to talk about. For several years, insurers kept prices artificially low while competing for market share and new revenue to invest in a booming stock market. As the bull market surged, investments by these historically con-

servative insurers rose to 10.6 percent in 1999, up from a more typical 3 percent in 1992.

With the market now in a slump, the insurers can no longer use investment gains to subsidize low rates.

The industry reported realized gains of $381 million last year, down 30 percent from the high point in 1998, according to the A.M. Best Company, one of the most comprehensive sources of insurance industry data. Remember that?

Dr. PALMISANO. Yes, sir.

Mr. CONYERS. Okay. And this phrase, or this sentence, "Insurers now acknowledge their miscalculation. 'We should have raised prices sooner,' said Mike Miller, the senior executive in charge of liability coverage at the St. Paul Companies."

Remember that?

Dr. PALMISANO. Yes, sir.

Mr. CONYERS. Okay. But in your testimony, Mr. President, you made no reference to the economic circumstances that have caused malpractice insurance premiums to rise.

Is that—well, you tell me why there was no reference made.

Dr. PALMISANO. Well, when—this was in the annual report 2002, Mr. Conyers—and it is good to see you again, sir. We did cite the latest information that we could get in our written testimony, which talks about the investment income being stable. We continue to gather information and knowledge.

But even if you take this statement, as—the statement that the insurers failed to raise the rates sooner, we would have had the crisis sooner, because the rates are determined, according to these experts, by frequency and severity in the defense costs.

Mr. CONYERS. So that is why you left it out?

Dr. PALMISANO. We didn't leave it out intentionally. We are just trying to give you something that is the latest information that we have.

Mr. CONYERS. I appreciate it.

If you get any new information along these lines, would you make it personally available to me?

Dr. PALMISANO. Yes, sir.

Mr. CONYERS. I am not able to make too many of those meetings.

Dr. PALMISANO. Thank you, I will.

Mr. CONYERS. Now, Mr. Smarr, this is known as true or false: A comparison of States that have enacted severe tort restrictions and those that have not reformed found no correlation between tort reform and insurance rates?

Mr. SMARR. I am not aware of the study.

Mr. CONYERS. But are you aware of the statement?

Mr. SMARR. I am aware of——

Mr. CONYERS. Is it true or false?

Mr. SMARR. If it is the statement that I am aware of, then that statement is false.

Mr. CONYERS. Okay. Are you aware of the Center for Justice and Democracy?

Mr. SMARR. I am.

Mr. CONYERS. They are the ones that did the report.

Mr. SMARR. Then the statement is false.

Mr. CONYERS. Because of who it came from?

Mr. SMARR. Because I have reviewed the work of the Center for Justice and Democracy, and I do not agree with it.

Mr. CONYERS. Okay. I see.

Number two: Some of the resisting States have experienced lower increases in rates while some States that enacted tort reforms experienced higher rate increases relative to national trends. True or false?

Mr. SMARR. If the source is the Center for Justice and Democracy, I do not agree.

Mr. CONYERS. Well, suppose it wasn't from them.

Mr. SMITH. The gentleman is recognized for an additional minute.

Mr. CONYERS. But, I mean, in your experience, we are not testing the Center for Justice and Democracy, we are testing—we are trying to seek your experience in this market, of which you are a professional, to determine whether you agree with these, regardless of where it came from.

Do you want me to read it again?

Mr. SMARR. Please.

Mr. CONYERS. Some of the resisting States experienced lower increases in insurance rates, while some States that enacted tort reforms experienced higher rate increases relative to the national trends.

Mr. SMARR. That statement could be true depending on the context and the States.

Mr. CONYERS. All right.

Mr. SMITH. If you will yield, I will grant the gentleman 2 additional minutes and hope he can conclude.

Mr. CONYERS. I thank you for your kindness.

In the practice of internal medicine, States with caps on damages in some States had higher premiums than States without caps.

Mr. SMARR. Again, sir, it would depend upon the analysis. I have seen studies that show that those are not truthful analyses.

Mr. CONYERS. Uh-huh. So what do you think about this as a general proposition?

Mr. SMARR. I think, in general, sir, that States that have adopted tort reforms have lower rates and have lower rates of increase than States that have not adopted tort reforms.

Mr. CONYERS. Good. Thank you very much.

Okay. Two more and we are through.

For general surgeons, insurance premiums have been 2.3 percent higher in States with caps on damages.

Mr. SMARR. I don't know that that is true.

Mr. CONYERS. Okay. And here is the last one. On average, malpractice premiums have been no higher in the 27 States that have no limitations on malpractice damages than in the 23 States that do have such limits.

Mr. SMARR. Again, I don't know that that is true.

Mr. CONYERS. All right. Well, you have done very well on this true and false test. I want to compliment you.

And I want to thank the Chairman for the additional time.

Mr. SMITH. Thank you, Mr. Conyers.

Before we adjourn, I want to recognize two Members so that they can each ask an additional question. And what I would ask them

to do is to keep the exchange short out of fairness to the Members who have already left, because they were not expecting to be able to ask additional questions.

The first person to be recognized is the gentleman from Virginia, Mr. Scott.

Mr. SCOTT. Thank you, Mr. Chairman. And, I will just ask a somewhat brief question. We are talking on the joint and several problem.

If Mr. Smarr could indicate what the costs would be in terms of expert witness fees to prove all of the cases—in Mrs. Keller's case, against the physician, a nurse, an ambulance driver, hospital, the neurologist, emergency room at the hospital. About what kind of expert witness fees are we talking about, and whether or not, under the bill, those fees would be covered by—within the attorneys' fees limitation, or would the plaintiff just have to pay these out of whatever was left of the settlement?

Mr. SMARR. Those fees—expenses are not paid, generally, out of the contingency portion of an award; they are in addition to the award.

As to the level of those fees, I have never seen any data on plaintiff expert witness fees and the like. I don't know that it is published.

Mr. SCOTT. You have expert witness fees on the defense side?

Mr. SMARR. Yes, we do.

Mr. SCOTT. How much do you pay your doctors to testify?

Mr. SMARR. I can't give you an accurate answer. But I do have that data, and I will provide it to you and to the Committee.

Mr. SMITH. Thank you, Mr. Scott.

The gentlewoman from Texas, Ms. Jackson Lee, is recognized for her question.

Ms. JACKSON LEE. As I indicated, I read some numbers into the record that show that whether or not you are in a crisis or not, the quality of care, or the quality of care in terms of a particular State is no better, no worse—Texas, 49th in quality of care; Louisiana, 51; and California, 44. In those States, those last two States have implemented some sort of reform.

Mr. SMITH. Are those figures, are they quality of care or expenditures, median expenditures?

Ms. JACKSON LEE. Quality of care.

Mr. SMITH. Who did the rankings of those?

Ms. JACKSON LEE. Quality of care, it was reported in the Journal for the American Medical Association. It was—the source is the American Health Quality Association on Care Delivered to Medicare Beneficiaries.

Mr. SMITH. Thank you.

Ms. JACKSON LEE. I don't have a quarrel, Dr. Palmisano, with you and the victims that are here in this room. I think the important point is, how can we resolve you being able to do your job weeding out bad doctors, promoting good doctors and saving the lives and helping these victims? So, Mr. Smarr, let me ask you these questions regarding who my quarrel actually is with.

First of all, I would like you to provide us with a 5-year reading of the profits of your organization. I don't know if it is in your documentation. I did not see it. But I would like to know whether you

would accept amendments regarding the idea that if a physician has had a clean record, as many of the physicians in my congressional district have had, that they will be guaranteed not only a, if you will, tabling or staying of their rates, but a decrease in their rates and, as well, that we would put in the language that those rates would remain in place for 5 years.

In addition, I would like to ask you the question as to how serious is the consideration—I know you are a corporation, and I am not sure what the incorporation status is—of your need for profits over the ability to ensure those who are seeking insurance?

My understanding is—from the physicians in my community is that basically no matter how well they practice medicine the insurance rate goes up, up and up, regardless of whether they are making profits or not, and mostly it goes up because you are attempting to make profits as opposed to serving as physicians and helping victims.

Mr. SMARR. Well, most of the doctors in Texas are insured by the Texas Medical Liability Trust, which is a physician-owned——

Ms. JACKSON LEE. Let us not speak to the Texas issue. I just used them as an example.

I want to ask whether your organization would accept those amendments of staying—of decreasing the cost of any physician who could show that they have not been sued and, as well, staying those costs for 5 years; and also to give me your record of profits over the last 5 years.

Mr. SMARR. The record of profits, I will be glad to provide to you. In fact, that is stated in my written testimony, the first exhibit.

Secondly, in terms of freezing rates for physicians that do not have claims experience, I can't commit to the members of my association that that would do that. But I——

Ms. JACKSON LEE. Wouldn't that be reasonable, that if you are not a problem, that your rates should not go up?

Mr. SMITH. We have been generous in allowing you extra time. But we will need to conclude our——

Ms. JACKSON LEE. I appreciate it, Mr. Chairman. I will let him answer the question.

Isn't that reasonable, Mr. Smarr?

Mr. SMARR. It is reasonable. It is being done now. Because insurers do employ merit rating plans where doctors that have—do not have significantly adverse loss experience either receive discounts, or those doctors that do have significantly adverse loss experience receive surcharges.

Ms. JACKSON LEE. So you wouldn't mind its being federalized in this bill?

Mr. SMITH. The gentlewoman's time has expired.

Ms. Jackson Lee, your time has expired.

Ms. JACKSON LEE. Thank you.

Mr. SMITH. I would like to thank all Members for their participation today, and also our witnesses for their input. You have been instructive and revealing, which will be helpful to us as we consider the HEALTH Act.

The Judiciary Committee stands adjourned.

[Whereupon, at 11:30 a.m., the Committee was adjourned.]

# APPENDIX

## STATEMENTS SUBMITTED FOR THE HEARING RECORD

### PREPARED STATEMENT OF THE ALLIANCE OF SPECIALTY MEDICINE

#### ASSESSING THE NEED TO ENACT MEDICAL LIABILITY REFORM

Chairman Sensenbrenner, and Members of the Committee, the Alliance of Specialty Medicine, a coalition of 13 medical organizations representing over 160,000 specialty care physicians in the United States, appreciates the opportunity to comment on the impact that our current medical litigation system is having on patient access to medical care and the need to enact medical liability reform legislation. The Alliance would also like to take this opportunity to thank you for the leadership that you and your committee have shown on this issue. We believe that the reforms contained in HR 5, the Help, Efficient, Accessible, Low Cost, Timely Health Care Act, which were approved by your Committee last year, will go a long way to solve the current medical liability crisis.

And it is a crisis. The media now report on a daily basis that the situation has become so critical that many physicians are forced to limit services, move to other states where the medical liability system is more stable, or retire altogether. Much of the "face" of this crisis has centered around the great difficulties that pregnant women are having in finding obstetricians to deliver their babies, but the simple truth is that this is a problem that potentially affects all of our citizens: the mother whose little boy has fallen off of the jungle gym and needs an orthopaedic surgeon to fix his broken arm; the teenager who has been in a serious car accident and needs a neurosurgeon to treat his severe head injury; the woman who needs a pathologist to evaluate her Pap smear to screen for cervical cancer; the elderly man who has a poor heart and needs a cardiologist or cardio-thoracic surgeon to unblock a clogged artery or replace a failing valve; the woman who has a family history of breast cancer and needs a radiologist to perform a mammography to make sure she is cancer free; the business man who needs a gastroenterologist to treat his ulcer; the man who needs a urologist to screen for prostate cancer; and the list goes on and on.

*Cause of the Crisis: The Current Medical Litigation System is Out of Control*

The root cause of this problem is quite simple: the unrestrained escalation of jury awards and settlements, in even a small number of medical liability cases, is driving up doctors' liability insurance premiums and is forcing some insurance companies out of business altogether. This problem is making it difficult, and sometimes impossible, for doctors to obtain affordable liability insurance so they can remain in practice. Adding to this is the fact that doctors distrust and fear the medical litigation system, causing them to alter the way they deliver medical care to their patients, and in some cases this fear is causing doctors to cease practicing altogether. There is a wide body of evidence to substantiate these conclusions:

**Medical Liability Awards are On the Rise**

Medical liability awards have been growing steadily, and according to Jury Verdict Research data, from 1994 to 2000 the median jury award rose by 176 percent. The number of mega-verdicts is also on the rise, with the proportion of million dollar plus awards increasing dramatically over this same time period. In 1996, 34 percent of all jury awards exceeded $1 million. Four years later, the number of million dollar awards increased to 52 percent, and the average jury award in 2000 was nearly $3.5 million.

**Medical Liability Insurance Premiums are Skyrocketing**

It is clear that the increasing number of multi-million dollar jury awards is driving up the costs of medical liability insurance and insurance companies are now

paying out approximately $1.40 for every premium dollar collected. Obviously, this is not sustainable, and this trend is therefore forcing insurance companies, which must set their rates based on anticipated future losses, to steeply increase doctors' medical liability premiums to ensure adequate reserves to pay future judgments. As a result, over the past several years, physicians across the country have faced double, and sometimes triple, digit rate increases. Alliance members, including high-risk specialists like neurosurgeons, orthopaedic surgeons and emergency physicians, have been disproportionately affected by these premium increases. For example:

- According to a national survey of neurosurgeons, between 2000 and 2002 the national average premium increase was 63%, from $44,493 to $72,682. In some states, neurosurgeons are now paying medical liability insurance premiums in excess of $300,000 per year.
- Utah orthopaedic surgeons have seen medical liability rate increases of 60% since last year and in Texas they are rising by more than 50 percent. In Pennsylvania, a survey conducted in June 2002 revealed rate increases as high as 59 percent. In other areas of the country, orthopaedic surgeons are finding that their premiums have risen by over 100 percent, even if they have never had a claim filed against them.
- Over the past several years, over 95 percent of emergency medicine physicians have experienced medical liability premium increases, with approximately 69 percent facing increases between 60 to 500 percent. This is attributed to the fact that emergency medicine physicians are almost always named in any litigation that arises from a patient encounter that begins in the emergency department. Since most hospital admissions now come through the emergency department, these doctors are experiencing steep premium rises even though the lawsuits against them may have no merit and result in either dismissal or a defendant's verdict.
- Even those specialists who are not in high-risk categories are affected by this upward trend in premium costs. For example, 80 percent of recently surveyed dermatologists reported that their premiums increased last year and those dermatologists who were insured by a state plan were paying nearly double what their colleagues were paying in the private market.

**Medical Liability Insurance is Unavailable**

Not only are medical liability insurance premiums rising at astronomical rates, but many doctors are also finding it increasingly difficult to obtain medical liability insurance at any price. Citing the increases in liability losses, several companies, including, St. Paul, MIXX, PHICO, Frontier Insurance Group and Doctors Insurance Reciprocal, have recently stopped selling medical liability insurance or have gone out of business, leaving thousands of doctors scrambling to find replacement coverage. Of the companies that have remained in the market, many are no longer renewing insurance coverage for existing policyholders and/or they are not issuing new insurance policies to new customers. This is particularly true in states that have no effective medical liability reform laws in place, where, for instance, in Mississippi fifteen insurers have left the market in the past five years. Alliance members have witnessed the impact of this problem first hand. For example:

- In 2002, nearly 40 percent of orthopaedic surgeons in Pennsylvania were not able to renew their medical liability coverage with the same carrier and 31 percent did not find new coverage. Close to 50 percent of Pennsylvania orthopaedic surgeons have reported that their liability policies will not be renewed for 2003.
- In 2002, 15 percent of dermatologists experienced difficulties securing their liability insurance. In some cases, dermatologists in solo practice who have never even been sued were forced to turn to the state for coverage because the remaining insurers in their area made a blanket decision to no longer insure solo practice physicians, regardless of specialty.
- Today in Mississippi, the only way a neurosurgeon can even be considered for coverage is if he or she joins an existing group that already is covered by the state medical society's insurance company. The other two companies providing insurance coverage in Mississippi will not issue new policies for neurosurgeons at all. In addition, neurosurgeons in Florida have been unable to obtain medical liability insurance at any cost, forcing them to "go bare" or self-insure.
- Recently one internationally-recognized pathologist, who has never had a claim filed against him, was turned down by three insurers and a fourth offered him a policy that was simply too expensive.

- Three of four insurance carriers with the largest market share in Missouri have stopped writing policies in that state. This means that physicians can often obtain a quote from only one company. For example, one group of 12 cardiologists could get only one quote with an 80 percent increase for 2003.

**Medical Litigation System Breeds Fear in Doctors**

Given the litigious nature of our society, every physician faces the reality that he or she may at some time be named in a medical liability lawsuit, whether meritorious or not, and the current medical litigation system breeds fear in all doctors. This fear of litigation, particularly among high-risk specialists, is a contributing factor in doctors' decisions to change the way in which they are practicing medicine. Data from a 2002 Harris Interactive study conducted for the Common Good, a bipartisan legal reform organization, validates this point. According to the data, nearly all physicians feel that unnecessary care is provided because of fear about litigation. To protect themselves in the event that they might be sued:

- 91 percent of doctors are ordering more tests than are medically needed;
- 85 percent of doctors refer patients to specialists more often than is necessary; and
- 73 percent of doctors suggest that patients have invasive procedures to confirm medical diagnoses

The report aptly concludes: "From the increased ordering of tests, medications, referrals, and procedures to increased paperwork and reluctance to offer off-duty medical assistance, the impact of the fear of litigation is far-reaching and profound."

*Result of the Crisis: Patient Access to Medical Care is in Jeopardy*

There are many casualties of the current medical liability crisis—but those affected the most are patients. Because the medical litigation system is broken, across the nation patients are finding it harder and harder to get access to the care they need, when they need it. As medical liability insurance becomes unaffordable or unavailable, more and more doctors, especially specialists, are no longer performing high-risk procedures, or they are being forced to move their practices to states with stable medical liability systems, or they are simply retiring from medical practice—all of which seriously impede patient access to care. Once gone, these doctors are hard to replace, and those states currently facing a medical liability crisis are having a difficult time recruiting new physicians to their communities adding to the shortage of doctors in many parts of the country. The combination of these factors is also now severely straining our nation's already stressed emergency medical system, as patients who have no access to doctors inevitably end up on the emergency department's doorsteps, further exacerbating the hospital emergency department overcrowding problem. A growing list of examples demonstrates just how serious this crisis is becoming:

**Doctors are No Longer Performing Complex and High-Risk Medical Procedures**

- According to a nationwide survey conducted last year, 43 percent of neurosurgeons reported that they are no longer performing high-risk surgery such as treating brain aneurysms, removing brain and spinal tumors, or complex spinal surgery. In addition, many neurosurgeons are no longer serving on-call to hospital emergency departments or operating on children.
- A recent survey found that 55 percent of orthopaedic surgeons nationwide have reduced the type of operational procedures they perform, with 39 percent avoiding performing spine surgery and 48 percent altering their practice in other ways, including eliminating emergency room call or trauma call.
- The elderly are particularly affected, as decreases in reimbursements for complex medical procedures have declined to the point where Medicare no longer even covers the cost of medical liability insurance. Specialists with a high volume of Medicare patients, such as cardiologists and cardio-thoracic surgeons, and their patients who need high-tech, lifesaving heart therapy, will feel the effects the most.

**Doctors, Trauma Centers and Other Medical Providers are Closing their Doors**

- In the case of neurosurgery, in 2001 alone, 327 board certified neurosurgeons retired, representing an alarming 10 percent of the neurosurgical workforce in the United States. Recently, the only neurosurgeon practicing at Cottonwood

Hospital in Salt Lake City, Utah quit practicing following a steep insurance premium increase.

- Recent press accounts are replete with stories about the closure of trauma centers in Pennsylvania, West Virginia, Nevada, Mississippi, Missouri and Florida because of a shortage of orthopaedic surgeons, neurosurgeons and other specialists available to provide emergency medical care. Chicago's trauma centers are also now vulnerable to closing or downgrading their status.
- In the last 18 months, nearly 700 mammography facilities have closed nationwide. The continued and steady closing of mammography facilities throughout the country has led to increased waiting times for women seeking both screening mammograms and diagnostic mammograms. The longer waiting times are now on the brink of affecting clinical outcomes for those women who must wait for a possible diagnosis of breast cancer.

**Doctors are Moving to States with a More Favorable Medical Liability Climate**

Every state that is experiencing a medical liability crisis reports that doctors are leaving in droves in search of another location in which to practice where the medical litigation climate is more favorable. The list of states experiencing the exodus of doctors continues to grow, and as with other elements of this crisis, specialists are most likely to "hit the road" in search of a safe haven state. For instance:

- Pennsylvania has been especially hard hit, and some counties no longer have any practicing orthopaedic surgeons. For example, Bedford County's only orthopaedic surgeon left the state in October 2001, and Pike and Monroe Counties are down from nine to five orthopaedic surgeons. Huntingdon County has just one orthopaedic surgeon remaining to take trauma call at two hospitals. The situation is the same in West Virginia, and a number of orthopaedic surgeons either have left the state or are scaling back their practices. At the end of 2002, five orthopaedic surgeons in Parkersburg moved their practice to Ohio.
- Neurosurgery's survey data show that nearly 19 percent of practicing neurosurgeons either plan to, or are considering, moving their practice to another state where the medical liability costs are relatively stable. Mississippi, for instance, has lost 35 percent of its neurosurgeons in the past two years, and the flight of neurosurgeons from Pennsylvania and West Virginia mirrors the Mississippi experience.

**The State of America's Health Now and in the Future is at Risk**

The combination of all the above factors is clearly placing the health of our nation's citizens at considerable risk. Because of the medical liability crisis, more and more people are finding it difficult to get the specialized medical attention they need, when they need it. This is causing a national health care emergency. Thus:

- When patients can't find a specialist close to home, they must sometimes travel great distances, often going out of state, to get their medical care.
- When fewer specialists are available, hospital emergency departments and trauma centers must shut their doors, and patients with emergency medical conditions lose critical life-saving time searching for an available emergency room.
- When specialists stop performing high-risk medical services, patients are often referred to academic medical centers, and these medical facilities are already overburdened and are ill equipped to handle the increase in patient volume.
- When specialists retire at an early age, the looming shortage of doctors is accelerated, which, if left unchecked will place additional burdens on the health care system as the population ages and requires more medical care from an increasingly shrinking pool of practicing doctors.
- When the practice of medicine becomes so uninviting, fewer and fewer of our nation's best and brightest will want to become doctors, thus jeopardizing our country's status as one of the finest health care systems in the world.

*Scope of the Crisis: A National Problem that Requires a Federal Solution*

Those who oppose federal legislation to address this crisis cite various reasons to support their contention that this is not a national problem that merits a federal solution. In particular, they note that the regulation of insurance and health care are generally state issues, and therefore principles of Federalism preclude federal legislation to address this problem. They are, however, wrong. The undisputed truth

is that this problem now touches nearly every American and a federal solution is therefore a national imperative. As the following demonstrate:

**Nearly All States are Facing a Medical Liability Crisis**

The AMA has identified 12 states that are in a medical liability crisis for all physicians. These include: Florida, Georgia, Mississippi, Nevada, New Jersey, New York, Ohio, Oregon, Pennsylvania, Texas, Washington and West Virginia. However, for many high-risk specialties, like neurosurgery and orthopaedic surgery, the situation is even more widespread than the AMA reports. A 2002 national survey of neurosurgeons identified 25 states that are in a severe medical liability crisis, with an additional 12 states in potential crisis. In addition to those identified by the AMA, the crisis states for neurosurgery include: Alabama, Arkansas, District of Columbia, Illinois, Kentucky, Missouri, New Hampshire, North Carolina, South Carolina, Rhode Island, Tennessee, Utah and Virginia.

**Every American Pays for the Costs of the Current Medical Litigation System**

According to the U.S. Department of Health and Human Services (HHS), in its report entitled, "Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing our Medical Liability System," the current medical litigation system imposes enormous direct and indirect costs on the health care system. These costs are passed on to all Americans in the form of increased health insurance premiums, higher out-of-pocket medical expenses and higher taxes. The report estimates that enacting federal medical liability legislation could save between $60–108 billion in health care costs each year. These savings would in turn lower the cost of health insurance and make health care more affordable and available to many more Americans.

**Federal Medical Liability Reform Will Save the Federal Government Money**

Each year, the Federal Government pays for the increased costs associated with the current medical litigation system through various health care programs, including Medicare, Medicaid, Community Health Centers and other health care programs for veterans and members of the armed forces. The Department of Health and Human Services estimates that the direct cost of medical liability insurance coverage and the indirect cost of defensive medicine, increases the Federal Government's costs of these health programs by $28.6 to $47.5 billion each year. In the above referenced report, HHS estimates that if reasonable limits were placed on non-economic damages, it would reduce Federal Government spending by $25.3 to $44.3 billion per year. The Congressional Budget Office (CBO), in its cost estimate of HR 4600, the HEALTH Act of 2002, confirms that passage of federal medical liability reform legislation that includes a cap on non-economic damages will increase federal tax revenues, and at the same time reduce the costs of federal health care programs.

**States Face Significant Barriers to Implementing Medical Liability Reforms**

Many states face barriers—some legal and some political—to enacting effective medical liability reform laws. Some states, including Texas, Florida, Ohio and Pennsylvania, have enacted medical liability reform laws, only to have their state Supreme Courts strike them down as unconstitutional. New laws passed by Mississippi and Nevada face certain court challenge, and it will be years before it is determined whether these laws pass state constitutional muster. Finally, in some other states, the issue has become a political one, effectively killing any chances for passage. As a consequence, despite the increasing medical liability crisis in many of these states, they are effectively powerless to act to effectively solve the problem.

*Solution to the Crisis: Medical Liability Reform Legislation Patterned After California's MICRA*

Fortunately, Congress does not need to start from scratch and identify and implement a solution that is untested. Faced with a similar crisis in the early 1970's, the state of California, with bipartisan support, enacted the Medical Injury Compensation Reform Act or MICRA. The key elements of MICRA include:

- Providing full compensation for all economic damages, including medical bills, lost wages, future earnings, custodial care and rehabilitation;
- Placing a fair and reasonable limit of $250,000 on non-economic damages, such as pain and suffering;

- Establishing a reasonable statute of limitations for filing a lawsuit;
- Allowing for periodic payments of damages rather than lump sum awards; and
- Ensuring that the bulk of any award goes to the plaintiffs, not attorneys

The clear and simple truth is that MICRA works. For nearly three decades, this law has ensured that legitimately injured patients get unfettered access to the courts and receive full compensation for their injuries, while at the same time providing stability to the medical liability insurance market to ensure that doctors can remain available to care for their patients. In a similar manner, the HEALTH Act will ensure that patients and doctors nationwide will reap the benefits of this rational approach to solving the professional liability crisis.

Consider the following points about the effectiveness of MICRA:

MICRA Fully Compensates Injured Patients

First and foremost, under MICRA, patients receive full compensation for legitimate injuries resulting from medical negligence. Detractors of federal reform legislation are attempting to obfuscate the facts by scaring the public and policymakers into believing that injured patients will only receive a maximum of $250,000 to compensate them for their injuries. This is simply not the case. Patients receive full compensation for all of their quantifiable needs, with up to an additional $250,000 for non-economic damages, such as pain and suffering. To demonstrate this fact, the Californians Allied for Patient Protection recently compiled a sample of total awards (including both economic and non-economic damages) provided to injured patients. For example:

December 2002
**$84,250,000 total award**
Alameda County
5-year-old boy with cerebral palsy and quadriplegia because of delayed treatment of jaundice after birth.

October 2002
**$59,317,500 total award**
Contra Costa County
3-year-old girl with cerebral palsy as a result of birth injury.

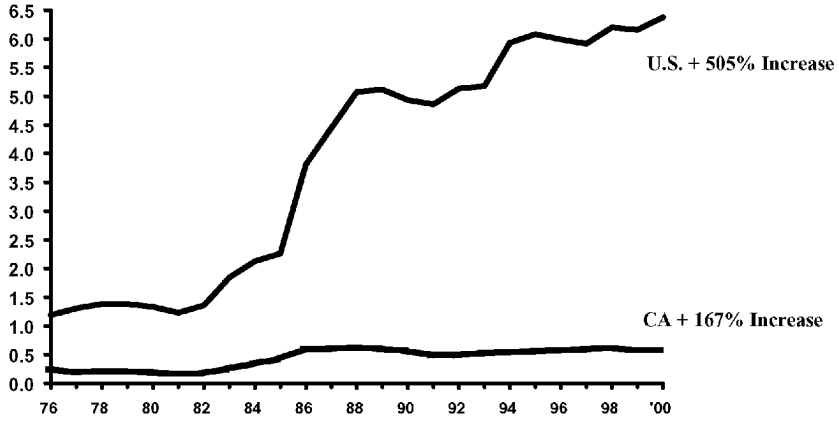
July 2002
**$12,558,852 total award**
Los Angeles County
30-year-old homemaker with brain damage because of lack of oxygen during recovery from surgery.

November 2000
**$27,573,922 total award**
San Bernardino County
25-year-old woman with quadriplegia because of failure to diagnose a spinal injury.

**MICRA Significantly Minimizes Premium Increases**

Opponents of reform cite statistics that over the past several years, premiums for doctors in California have also been rising; thus proving that MICRA does not have any impact in holding down the costs of medical liability insurance. While it is true that premiums are on the rise in nearly all states, including California, the rate of increase of premiums for California doctors is significantly lower than in other states, and over time, MICRA has, in fact, stabilized medical liability insurance premiums as compared to the rate of increase in the rest of the country. As the following chart demonstrates, from 1976 to 2000, premiums for physicians in California have risen only 167 percent as compared to an increase of 505 percent for the entire United States.

Premium Growth: California vs. U. S. Premiums 1976-2000




Source: NAIC Profitability Study, 2000

Data collected from high-risk medical specialties from 2000 to 2002 also validate these trends. For example, according to a nationwide survey of neurosurgeons, the national average premium increase for California neurosurgeons was 39 percent as compared to 63 percent for neurosurgeons in the entire country. In addition, the same survey clearly demonstrated that the rate of increase for an individual neurosurgeon in Los Angeles, California, as compared to other neurosurgeons who practice medicine in crisis states where there are no reforms in place, is significantly lower. The average rate of increase for the neurosurgeons in these non-reform states was 143 percent as compared to just 8 percent in Los Angeles, CA.

| State/City | 2000 | 2002 | Percentage Increase |
|---|---|---|---|
| **Los Angeles, CA** | **$ 48,000** | **$ 52,000** | **8%** |
| West Palm, FL | 58,000 | 210,000 | 262% |
| Cleveland, OH | 75,675 | 167,941 | 122% |
| Oaklawn, IL | 110,000 | 282,720 | 157% |
| Philadelphia, PA | 90,000 | 190,000 | 111% |
| New York, NY | 154,890 | 251,126 | 62% |

Source: American Association of Neurological Surgeons /Congress of Neurological Surgeons Nationwide Survey April 2002

The Alliance does acknowledge that despite the successful reforms contained in MICRA, the average medical liability claim in California has outpaced the rate of inflation. This is in large part due to the fact that economic damages are not limited under MICRA and have grown as a component of medical liability claims. Notwithstanding this, however, the undisputed fact remains that MICRA prevents runaway juries from awarding outrageous awards for subjective, arbitrary and often unquantifiable non-economic damages, which allows insurance companies to adequately predict future lawsuit awards, bring stability the health care delivery system.

**Federal Government Validates that MICRA Works**

U.S. Government experts agree that MICRA does in fact hold down the costs of medical liability insurance, and over the years there have been a number of studies that have identified MICRA's $250,000 cap on non-economic damages as a crit-

ical element in stabilizing premium costs. For example, dating back to September 1993, the former U.S. Office of Technology Assessment (OTA), in a report entitled, "Impact of Legal Reforms on Medical Malpractice Costs," concluded that caps on damages were consistently found to be an effective mechanism for lowering medical liability insurance premiums. Most recently, the previously referenced HHS report, "Confronting the New Health Care Crisis" and the CBO cost estimate report of the HEALTH Act, came to the same conclusion.

*Justification for Federal Reform Legislation: Americans Overwhelmingly Support a MICRA-Style Solution*

Americans are becoming acutely aware of the impact that this crisis is having on our nation's health care system, and overwhelmingly favor having Congress pass legislation to reform the current medical liability system and create one that balances the rights of patients to seek and obtain appropriate compensation for injuries caused by medical negligence against the right of all our citizens to have continued access to medical care. Two recent polls clearly demonstrate this support. In January 2003, Gallup conducted a poll on this issue and found the following:

- Americans believe that the medical liability insurance issue is either a major problem (56%) or a health care crisis (18%);
- 72 percent favor passing a law that would limit the amount that patients can be awarded for their emotional pain and suffering; and
- 57 percent responded that they think patients bring too many lawsuits against doctors

This Gallup poll confirms the findings of last year's Wirthlin Worldwide study conducted for the Health Care Liability Alliance (HCLA), which found that:

- 78 percent of Americans are concerned that skyrocketing medical liability costs could limit their access to care;
- 73 percent favor a federal law that guarantees injured patients full payment for lost wages and medical costs and reasonable limits on awards for "pain and suffering" in medical liability cases; and
- 48 percent believe the number of medical liability lawsuits against doctors is higher than justified

CONCLUSION

We have reached a very important juncture in the evolution of the U.S. health care system. At a time when lifesaving scientific advances are being made in nearly every area of health care, patients across the country are facing a situation in which access to health care is in serious jeopardy. Thus, as the Congress deliberates the many facets of this issue, the Alliance urges you to continue to keep in mind that this issue is not about doctors, lawyers and insurance companies. Rather, it is about patients and their ability to continue to receive timely and consistent access to quality medical care. By reforming the medical litigation system, the crisis will ultimately be abated. Patients are calling for reform. Doctors are calling for reform. President Bush is calling for reform. And the Alliance urges the Congress to heed these calls and, at a minimum, pass the HEALTH Act so all Americans are able to find a doctor when they most need one. Ultimately, when the question "Will your doctor be there?" is asked, the answer must be an unqualified yes.

Thank you for considering our comments and recommendations. The Alliance of Specialty Medicine, whose mission is to improve access to quality medical care for all Americans through the unified voice of specialty physicians promoting sound federal policy, stands ready to assist you on this and other important health care policy issues facing our nation.

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PREPARED STATEMENT OF MARY R. GREALY

Our liability system is broken. If it is not fixed soon, it will break our health care system as well.

One of the founding principles of the Healthcare Leadership Council (HLC) B which represents the CEO's of the nation's leading health care companies and organizations B is that patients should have access to high quality health care. Skyrocketing liability costs threaten patient access to quality care. This is no longer simply about lawyers and doctors. This is about patients.

The cost of excessive jury awards is causing staggering increases in medical liability premiums. Between 1996 and 1999, average jury awards in medical liability

cases have increased by 76 percent. These spiraling increases add directly to the cost of health care, contributing significantly to premium costs and the growing number of uninsured Americans.

Just as harmful to patients and consumers, however, are the indirect costs of the crisis. Patients are increasingly Apaying@ for excessive litigation by losing access to medical specialists such as obstetricians and surgeons. An estimated 1 in 11 obstetricians/gynecologists say they have strictly limited their services solely to gynecology due to the malpractice crisis. In some areas, the situation is far worse. In Miami, average annual malpractice premiums for Ob-Gyns are $210,578, while the average salary for an Ob-Gyn in Florida is $118, 435. In Wyoming, premiums average $116,000, while average salaries for Ob-Gyns are $108,700.

As medical malpractice insurance rates skyrocket B or become unavailable B medical specialists such as neurosurgeons, orthopaedic surgeons and obstetricians/gynecologists are leaving states such as Pennsylvania, Mississippi, West Virginia, New Jersey, Florida and others. While these states have been in the news lately, the crisis goes far beyond the 13 Acrisis@ states. It is estimated that as many as 30 other states are in Anear crisis@ and will soon join the ranks of states where patient access is endangered.

Patients also are losing access to nearby hospitals, trauma centers, and other facilities as a result of the crisis. Patients are subjected to, and pay for, unnecessary tests and procedures as physicians must practice Adefensive medicine.@ In addition, patients ultimately are the ones who suffer when new drug therapies and medical technologies are not developed due to litigation or the fear of it.

The cause of the liability crisis is clear. Medical malpractice insurance rates are set prospectively. These rates are set primarily on the basis of projections of jury awards. This trend line is in one direction: straight up. Solving the cost problem requires dealing with the size and unpredictability of these awards. The bottom line is that medical malpractice premiums cannot keep up with claims. A typical state is Oregon, where a Governor's task force reported that medical liability insurers paid out $71 million in losses and defense costs, while receiving $50 million in premiums over the same period. In Ohio, medical malpractice insurers are losing $1.62 for every $1 in premiums. Clearly these trends are unsustainable and will drive more physicians out of practice.

The only proven way to bring these costs under control B while actually enhancing patients' ability to recover economic damages for injuries B are reforms which include capping non-economic and punitive damages, establishing reasonable levels for attorneys' fees, and setting fair share rules for joint and several liability.

HLC strongly supports these and other reforms embodied in the Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2003 (H.R. 5). We urge that the Committee favorably report H.R. 5 to the full House for consideration. We stand ready to work with you to address this growing crisis.

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PREPARED STATEMENT OF FRANK CLEMENTE

On behalf of Public Citizen's 125,000 members, I am pleased to provide this testimony to the Judiciary Committee for the hearing record on H.R. 5, the HEALTH Act of 2003.

Public Citizen strongly opposes H.R. 5. We sympathize with the plight of some medical specialists who are experiencing a large spike in malpractice insurance premiums. But that is a temporary problem caused by the insurance cycle. Yet, H.R. 5 proposes a permanent—and draconian—reduction in patients' access to the courts, which plays no role in this temporary "crisis." It would be a travesty of justice for Congress to take away patients' legal rights in the name of protecting insurance company profits and doctors' income. Caps on damages hurt those most seriously injured. The fact is that the legal system is all patients have to ensure just compensation for injury and to force improvements in patient safety. It's clear that the current regulatory system is not up to the task.

This testimony consists of four elements:

- A summary of the key facts about the medical malpractice issue, as reported by reputable government and private sources.
- A summary of Public Citizen's objections to this anti-consumer and anti-patient legislation.
- A briefing book prepared by Public Citizen entitled "Medical Misdiagnosis: Challenging the Malpractice Claims of the Doctors' Lobby." Perhaps the greatest malpractice in this debate has been the promulgation of phony facts from the medical lobby. This report cites numerous government studies—many from the Bush Ad-

ministration—and reputable academic studies to challenge the claims of H.R. 5's proponents.

- Summaries of Public Citizen reports on the medical malpractice "crisis" in nine states—Arkansas, Florida, Mississippi, Nevada, New Jersey, Pennsylvania, Rhode Island, Texas, and West Virginia. The American Medical Association has declared most of these states "crisis" states. The striking thing about the government data contained in these reports is that they provide concrete evidence that the "crisis" is not a result of the legal system.

In conclusion, we encourage the committee to focus on the true medical malpractice crisis—the 50,000 to 100,000 Americans who are killed each year from preventable medical errors, and the many more people who get injured each year and whose lives have often been shattered.

It is very unfortunate that rather than reducing the real threats that current medical care poses to their patients, the doctor's lobby has proposed to shift the costs of injuries onto innocent individuals, their families, voluntary organizations and taxpayers. Doctors, patients and consumers should be allies on this issue—which fundamentally comes down to improving the quality of medical care in the U.S.—not be pitted against each other.

FACTS ABOUT MEDICAL MALPRACTICE

The facts do not support the contention that our tort system needs radical change. Here is a summary of findings from key government reports and academic studies. They are explored in more detail in the attached briefing book.

*Costs of Medical Negligence to Patients*

- Between 44,000 to 98,000 Americans die in hospitals each year due to preventable medical errors. (Institute of Medicine, *To Err Is Human: Building a Safer Health System*, 2000.)
- The annual costs to society for medical errors in hospitals at $17 billion to $29 billion. (Institute of Medicine, *To Err Is Human: Building a Safer Health System*, 2000.)
- The total amount spent on medical malpractice insurance in 2000 was $6.4 billion—at least three to five times less than the Institute of Medicine's estimate of the costs of malpractice to society. (National Association of Insurance Commissioners, *Statistical Compilation of Annual Statement Information for Property/Casualty Insurance Companies in 2000*, (2001).)

*Frequency of Medical Malpractice Claims*

- Only one in eight preventable medical errors committed in hospitals results in a malpractice claim. (Harvard Medical Practice Study Group, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York*, 1990.)
- From 1996 through 1999, Florida hospitals reported 19,885 incidents but only 3,177 medical malpractice claims. In other words, for every 6 medical errors only 1 claim is filed. (The Agency for Health Care Administration; Division of Health Quality Assurance. Reported malpractice claims by district compared to reported adverse incidents 1996, 1997, 1998, 1999.)
- The number of new medical malpractice claims declined by about four percent between 1995 and 2000. There were 90,212 claims filed in 1995 and 86,480 claims filed in 2000. (National Association of Insurance Commissioners, *Statistical Compilation of Annual Statement Information for Property/Casualty Insurance Companies in 2000*, 2001.)
- Punitive Damages are awarded in less than 1 percent of medical malpractice cases. (Bureau of Justice Statistics, 1996.)

*Physicians' Costs of Medical Malpractice Insurance*

- Malpractice insurance costs amount to only 3.2 percent of the average physician's revenues. (Official Transcript, Medicare Payment Advisory Commission, Public Meeting, December 12, 2002.)
- While medical costs have increased by 113 percent since 1987, the total amount spent on medical malpractice insurance has increased by just 52 percent over that time, less than half of medical services inflation. (Bureau of Labor Statistics—Medical Services CPI; Best's Aggregates and Averages.)
- The median medical malpractice payout by a physician to a patient rose 35 percent from 1997 to 2000, from $100,000 to $135,000. (National Practitioner Data

Bank Annual Reports, 1997 through 2001.) But during the same time, the average premium for single health insurance coverage has increased by 39 percent. (Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits Surveys, 1998–2002; National Practitioner Data Bank Annual Reports, 1997 through 2001.)

*Medical Malpractice Award Trends*

- The size of damage awards has been steady since 1991. The mean payout was $135,941 in 2001, up 8.7 percent from $125,000 in 2000. Over ten years, malpractice payouts have grown an average of 6.2 percent per year. That's almost exactly the rate of medical inflation: an average of 6.7 percent between 1990 and 2001. (National Practitioner Data Bank and the Journal of Health Affairs, as quoted by Lorraine Woellert, *Commentary: A Second Opinion on the Malpractice Plague, Business Week*, March 3, 2003.)
- Malpractice payouts by physicians and their insurers were a mere $4.5 billion in 2001—less than 1 percent of the country's overall health care costs of $1.4 trillion. (National Practitioner Data Bank, as quoted in *Business Week*, March 3, 2003.)
- In 2001, only 895 out of 16,676 payouts, or about 5 percent, topped $1 million. (National Practitioner Data Bank, as quoted in *Business Week*, March 3, 2003.)

*Insurance Industry Economics Have Caused the Premium Price Spike*

- "For several years, insurers kept prices artificially low while competing for market share and new revenue to invest in a booming stock market. As the bull market surged, investments by these historically conservative insurers rose to 10.6% in 1999, up from a more typical 3% in 1992. With the market now in a slump, the insurers can no longer use investment gains to subsidize low rates." (American Medical Association Report 35 of the Board of Trustees (A–02), available at *http://www.ama-assn.org/ama1/upload/mm/annual02/bot35a02.rtf.*)
- Premiums charged do not track losses paid, but instead rise and fall in concert with the state of the economy. When the economy is booming and investment returns are high, companies maintain premiums at modest levels; however, when the economy falters and interest rates fall, companies increase premiums in response. (J. Robert Hunter, Americans for Insurance Reform, "Medical Malpractice Insurance: Stable Losses/Unstable Rates," October 10, 2002. See also: *http://www.insurance-reform.org/StableLosses.pdf.*)

*Small Number of Dangerous Doctors Commit Most Malpractice*

- Only 5 percent of doctors (1 out of 20) are responsible for 54 percent of malpractice payouts. (National Practitioner Data Bank, Sept. 1, 1990-Sept. 30, 2002.)
- Only 8 percent of doctors (1 out of 12) with 2 or more malpractice payouts have been disciplined by their state medical board. (National Practitioner Data Bank, Sept. 1, 1990-Sept. 30, 2002.)
- Only 17 percent of doctors (1 out of 6) who have made 5 or more malpractice payouts have been disciplined by their state medical board. (National Practitioner Data Bank, Sept. 1, 1990-Sept. 30, 2002.)

THE UNFAIRNESS OF H.R. 5

H.R. 5 would do nothing to reduce the incidence of medical errors. Instead, it would reduce compensation to victims of malpractice and make it harder for them to seek justice. Public Citizen's objections to H.R. 5 include:

**Broad scope: not just doctors are let off the hook.** While sponsors say that H.R. 5 is intended to benefit doctors, other special interests are along for the ride. Nursing home operators, medical device manufacturers, pharmaceutical companies, hospitals, and even HMOs are all covered by the bill's definition of "health care liability claim" and would be equally insulated from liability.

**Reckless conduct no longer subject to punitive damages.** Punitive damages are rarely awarded in medical malpractice cases, but the threat of punitive damages is important to deterring reckless disregard for patient safety by HMOs, nursing homes, and drug and medical device manufacturers. H.R. 5 would reward these special interests with a benefit that even the conservative 104th Congress rejected-a complete ban on punitive damages for reckless conduct.

**$250,000 cap on non-economic damages.** Awards for non-economic loss (pain and suffering resulting from injuries such as lost childbearing ability, disfigurement, and paralysis) compensate for the human suffering caused by medical negligence and defective medical products. Typically, such damages exceed $250,000 only in

cases of NAIC Level 6 injury severity or higher[1]—that is, cases involving permanent significant injuries. Thus, the cap will not affect patients with minor injuries; instead, it targets only victims of injuries such as deafness, blindness, loss of limb or organ, paraplegia, or severe brain damage. Since the cap makes no allowance for inflation, its arbitrary limits become more unjust as each day passes.

**Caps on attorney fees.** Conservatives often say that "price controls reduce supply." In H.R. 5 they practice what they preach. By limiting attorney fees, the sponsors hope to reduce the supply of representation for victims. These price controls will almost certainly succeed—they reduce the potential rewards of litigation that already carries with it high risks in terms of the expenses attorneys must advance and the sympathy that juries have for doctors. By drastically altering the risk/reward formula, H.R. 5 will prevent many victims from obtaining legal counsel.

**Leaves patients holding the bag when a doctor is insolvent.** The doctrine of joint and several liability says that when two defendants, such as a doctor and a hospital, are both found liable for negligence, a plaintiff may collect the entire award from either of them if necessary. H.R. 5 would change this rule, and leave patients with no recovery for the share of damages assigned to an uninsured, underinsured, or bankrupt defendant.

**Lets defendants control payouts for future damages.** By instituting a "periodic payment rule" for future damages over $100,000, the bill would allow defendants and insurance companies to string out payments for future damages over the life expectancy of the victim, rather than have to pay up front. This is money the jury has determined rightfully belongs to the plaintiff, yet defendants and insurers would be able to invest and earn interest on the vast majority of a plaintiff's damage award. Victims would be left to cope with unexpected needs or changing medical costs and increased transportation and housing costs. The bill would provide no protection to the victim if his or her needs change, or if the insurance company becomes insolvent.

**Shortened statute of limitations to one year after discovery of the injury.** This severe limitation will extinguish many meritorious claims. Although in most cases an injury is immediately apparent, a victim may not know until much later whether the injury was caused by malpractice. The law in most states starts the limitation period running from the discovery of the malpractice, not discovery of the injury.

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[1] Institute for Legislative Practice, *Jury Verdicts in Medical Malpractice Cases and the MICRA Cap* (1999); "Jury Awards for Medical Malpractice and Post-verdict Adjustments of Those Awards," 48 DePaul L. Rev. 265 (1998)

# Medical Misdiagnosis:
## Challenging the Malpractice Claims of the Doctors' Lobby


**Congress Watch**
**January 2003**

## Acknowledgments

This report was written by Public Citizen's Congress Watch Legislative Counsel Jackson Williams, based on extensive research provided by Civil Justice Fellow Gretchen Denk, Legislative Assistant Rebecca Romo, Special Counsel Barry Boughton, and Senior Researcher Andrew Benore. Congress Watch Director Frank Clemente provided significant editorial direction. State supplementary reports were written by Research Director Neal Pattison and Civil Justice Fellow Gretchen Denk.

## About Public Citizen

Public Citizen is a 150,000 member non-profit organization based in Washington, D.C. representing consumer interests through lobbying, litigation, research and public education. Since its founding by Ralph Nader in 1971, Public Citizen has fought for consumer rights in the marketplace, safe and affordable health care, campaign finance reform, fair trade, clean and safe energy sources, and corporate and government accountability. Public Citizen has five divisions and is active in every public forum: Congress, the courts, governmental agencies and the media. Congress Watch is one of the five divisions.


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# Medical Misdiagnosis:

## Challenging the Malpractice Claims of the Doctors' Lobby

### Table of Contents

# Medical Misdiagnosis: Challenging the Malpractice Claims of the Doctors' Lobby

## Executive Summary

The major findings in this report are the following:

**Doctors' Attacks on the Tort System Are a Misdiagnosis that Diverts Attention from an Epidemic of Medical Errors and Unsafe Practices**

- **Between 44,000 to 98,000 Americans die in hospitals each year due to *preventable* medical errors, according to the Institute of Medicine (IOM).** By comparison, the annual death toll is 43,000 from automobile accidents, 42,000 from breast cancer, and 15,000 from AIDS.

- **The costs of doctor negligence and the medical liability system is much greater for patients than doctors.** The IOM estimates the annual costs to society for medical errors in hospitals at $17 billion to $29 billion. These costs include disability and health care costs, lost income, lost household production and the personal costs of care. They do not include medical malpractice occurring outside the hospital setting. By contrast, the National Association of Insurance Commissioners reports that the total amount spent on medical malpractice insurance in 2000 was $6.4 billion – at least three to five times less than the costs of malpractice to society.

**Rather than Facing "Runaway Litigation," Doctors Benefit from a Claims Gap**

- **The landmark Harvard Medical Practice Study and other studies have found that only a small percentage of medical errors result in lawsuits.** Twelve years ago, Harvard researchers found that only one in eight preventable medical errors committed in hospitals results in a malpractice claim. Researchers replicating this study made similar findings in Utah and Colorado. From 1996 through 1999, Florida hospitals reported 19,885 incidents but only 3,177 medical malpractice claims. In other words, for every 6 medical errors only 1 claim is filed.

- **Malpractice insurance costs amount to only 3.2 percent of the average physician's revenues.** According to experts at the Medicare Payment Advisory Commission (MedPAC), liability insurance premiums make up just a tiny part of a physician's expenses and have increased by only 4.4 percent over the past year. The increase in this expense is noticeable primarily because of the decreases in reimbursements that doctors are receiving from HMOs and government health programs.

**Increases in Medical Malpractice Premiums and Payments Track — And Do Not Exceed — Increased Costs of Injuries**

- **Malpractice insurance costs have risen at half the rate of medical inflation, debunking the myth of "out-of-control juries."** While medical costs have increased by 113 percent since 1987, the total amount spent on medical malpractice insurance has increased by just 52 percent over that time—less than half of medical services inflation.

- **Government data shows that medical malpractice awards have increased at a much slower pace than claimed by Jury Verdict Research.** According to the federal government's National Practitioner Data Bank (NPDB), the median medical malpractice payment by a physician to a patient rose 35 percent from 1997 to 2001, from $100,000 to $135,000. By contrast, data from Jury Verdict Research (JVR), a private research firm, shows that awards rose 100 percent from 1997 to 2000, from $503,000 to $1 million. The reasons for the huge difference: JVR only collects jury *verdict* information that is reported to it by attorneys, court clerks and stringers. The NPDB is the most comprehensive source of information that exists because it includes both verdicts *and* settlements. Ninety-six percent of all medical malpractice cases are settled, as opposed to decided by a jury, and settlements result in much lower awards than jury verdicts.

- **Government data shows that medical malpractice awards have increased at a slower pace than health insurance premiums.** According to the federal government's National Practitioner Data Bank, the median medical malpractice payment by a physician to a patient rose 35 percent from 1997 to 2000, from $100,000 to $135,000. But during the same time, the average premium for single health insurance coverage has increased by 39 percent. [See Figure, "Growth in Health Insurance Costs and Malpractice Awards Compared."] Payments for health care costs, which directly affect health insurance premiums, make up the lion's share of most medical malpractice awards.

**The Spike in Medical Liability Premiums Was Caused by the Insurance Cycle, Not By New Claims or "Skyrocketing" Jury Verdicts**

- **There is no growth in the number of new medical malpractice claims.** According to the National Association of Insurance Commissioners (NAIC), the number of new medical malpractice claims declined by about four percent between 1995 and 2000. There were 90,212 claims filed in 1995; 84,741 in 1996; 85,613 in 1997; 86,211 in 1998; 89,311 in 1999; and 86,480 in 2000.

- **For much of the 1990s, doctors benefited from artificially lower premiums.** According to the International Risk Management Institute (IRMI), one of the leading analysts of commercial insurance issues, "What is happening to the market for medical malpractice insurance in 2001 is a direct result of trends and events present since the mid to late 1990s. Throughout the 1990s, and reaching a peak around 1997 and 1998, insurers were on a quest for market share, that is, they were driven more by the amount of premium they could book rather than the adequacy of premiums to pay losses. In large part this emphasis on market share was driven by a desire to accumulate large amounts of capital with which to turn into investment income." IRMI also noted: "Clearly a business cannot continue operating in that fashion indefinitely."

- **One major insurer appears to have triggered a "crisis" in at least four states studied.** Case studies on Mississippi, Nevada, Pennsylvania, and West Virginia in this briefing book show that the "crisis" in at least these four states was triggered after a leading company, The St. Paul Companies, Inc., withdrew from the medical liability marketplace in December 2001. That decision had more to do with St. Paul's reckless cash flow policies than it did with malpractice claims or jury awards.

- **Medical liability premiums track investment results.** J. Robert Hunter, one of the country's most knowledgeable insurance actuaries and director of insurance for Consumer Federation of America, recently analyzed the growth in medical liability premiums. He found that premiums charged do not track losses paid, but instead rise and fall in concert with the state of the economy. When the economy is booming and investment returns are high, companies maintain premiums at modest levels; however, when the economy falters and interest rates fall, companies increase premiums in response.

**"Repeat Offender" Physicians Are Responsible for the Bulk of Medical Malpractice Costs**

- **Five percent of doctors are responsible for 54 percent of malpractice in the U.S.** Public Citizen's analysis of the federal government's National Practitioner Data Bank, which covers malpractice judgments and settlements since September 1990, found that 5.1 percent of doctors (35,009) have paid two or more malpractice awards to patients. These doctors are responsible for 54 percent of all payouts reported to the Data Bank. Of these, only 7.6 percent have ever been disciplined by state medical boards. Only 17 percent of doctors (1 out of 6) who have made 5 or more malpractice payouts have been disciplined.

**Few, If Any, Malpractice Lawsuits Are "Frivolous"**

- **Plaintiffs drop ten times more claims than they pursue**. Based on Physician Insurer Association of America (PIAA) figures, Public Citizen estimates that about 54 percent of claims are being abandoned by patients. Attorneys often may send a statutorily required notice of intent to claim or file a lawsuit in order to meet the requirements of the statute of limitations but, after collecting medical records and consulting with experts, decide not to pursue the claim. We estimate that the number of cases withdrawn voluntarily by plaintiffs was 92,621, *ten times* the number of cases that were taken to trial and lost during that period (9,293). The percentage of claims pursued by plaintiffs to final rejection by a jury is only *five percent.*

- **The small number of claims pursued to a defense verdict are not frivolous.** Researchers at the American Society of Anesthesiologists arranged for pairs of doctors to review 103 randomly selected medical negligence claims files. The doctors were asked to judge whether the anesthesiologist in question had acted reasonably and prudently. The doctors only agreed on the appropriateness of care in 62 percent of the cases; they disagreed in 38 percent of cases. The researchers concluded, "These observations indicate that neutral experts (the reviews were conducted in a situation that did not involve advocacy or financial compensation) commonly disagree in their assessments when using the accepted standard of reasonable and prudent care."

### So-called "Non-Economic" Damages Are Real and Not Awarded Randomly

- **"Non-economic" damages aren't as easy to quantify as lost wages or medical bills, but they compensate real injuries.** So-called "non-economic" damages are awarded for the pain and suffering that accompany any loss of normal functions (e.g. blindness, paralysis, sexual dysfunction, lost bowel and bladder control) and inability to engage in daily activities or to pursue hobbies, such as hunting and fishing. This category also encompasses damages for disfigurement and loss of fertility. According to PIAA, the average payment between 1985 and 2001 for a "grave injury," which encompasses paralysis, was only $454,454.

- **No evidence supports the claim that jury verdicts are random "jackpots."** Studies conducted in California, Florida, North Carolina, New York, and Ohio have found that jury verdicts bear a reasonable relationship to the severity of the harm suffered. In total the studies examined more than 3,500 medical malpractice jury verdicts and found a consistent relationship between the severity of the injury and the size of the verdict. Uniformly the authors concluded that their findings did not support the contention that jury verdicts are frequently unpredictable and irrational.

### Empirical Evidence Does not Confirm the Existence of "Defensive Medicine" — Patient Injuries Refute It

- **The Congressional Budget Office has rejected the defensive medicine theory.** CBO was asked to quantify the savings from reduced "defensive medicine" if Congress passed H.R. 4600. This bill, which passed the House in 2002, contained very stringent restrictions on a patient's ability to recover damages. CBO declined, saying that any such "estimates are speculative in nature, relying, for the most part, on surveys of physicians' responses to hypothetical clinical situations, and clinical studies of the effectiveness of certain intensive treatments. Compounding the uncertainty about the magnitude of spending for defensive medicine, there is little empirical evidence on the effect of medical malpractice tort controls on spending for defensive medicine and, more generally, on overall health care spending. Using broader measures of spending, CBO's initial analysis could find no statistically significant connection between malpractice tort limits and overall health care spending."

### Solutions to Reduce Medical Errors and Long-term Insurance Rates

- **Implement patient safety measures proposed by the Institute of Medicine.** The "systems approach" to patient safety advocated by the Institute of Medicine shows promise. Some three years after the release of its report little has been done to establish mandatory nationwide error reporting systems, identify unsafe practices, or raise performance standards. Although experts using the systems approach have identified a number of promising strategies to reduce malpractice, few have been implemented.

- **Open the National Practitioner Data Bank.** Information about doctor discipline, including state sanctions, hospital disciplinary actions and medical malpractice awards is now contained in the National Practitioner Data Bank. HMOs, hospitals and medical boards can look at the National Practitioner Data Bank but consumers cannot, because the names of

physicians in the database are kept secret from the public. Congress should lift the veil of secrecy and allow the people who have the most to lose from questionable doctors to get the information they need to protect themselves and their families.

- **Improve oversight of physicians.** Less than one-half of one percent of the nation's doctors face any serious state sanctions each year. 2,708 total serious disciplinary actions a year, the number state medical boards took in 2001, are a pittance given estimates that between 44,000 and 98,000 deaths of hospitalized patients are caused by medical errors annually. State medical boards should be strengthened and more doctors should be disciplined for incompetence.

- **Limit physicians' workweek to reduce hazards created by fatigue.** American medical residents work among the highest—if not the highest—number of hours in the professional world. They work up to 120 hours a week, including 36-hour shifts for several weeks at a time. After 24 hours of wakefulness, cognitive function deteriorates to a level equivalent to having a 0.10% blood alcohol level. In other words, doctors who would be considered too unsafe to drive may still treat patients for 12 more hours. Residents should be limited to an 80-hour workweek.

# Introduction

In November 1999, the Institute of Medicine released its report on patient safety in the U.S. The report's findings were shocking – that between 44,000 and 98,000 Americans die annually as a result of preventable medical errors. But the report raised hopes among consumer advocates that what we knew to be a major public health problem would finally be addressed by policymakers.

Unfortunately, the public's hopes were quickly dashed. The economic downturn that began the following year, and which in turn led to an insurance market decline, led to stiff but temporary increases in medical liability premiums. The medical community saw the rate hikes as a golden lobbying opportunity. Medical providers ceased negotiations on patient safety legislation, and for the third time in as many decades, they declared war on our legal system.

The tactics that have been employed in their war are deplorable. The first casualty was the truth. Doctors and their lobbyists claim that hard-working American citizens undergo a hideous transformation when they take a juror's oath: they become part of "out-of-control" juries and issue "skyrocketing" verdicts. Such verdicts, say the medical lobby, are the cause of increased liability premiums.

This report demonstrates the falsity of this charge. The facts are these: Insurance premiums are rising as a result of a business cycle wholly unrelated to tort claims. New claims filings are flat. Liability insurance expenditures and victim compensation are barely keeping pace with increases in health care costs. Only a fraction of patients harmed by malpractice ever seek compensation.

The doctors' message has been, "Give us what we want or we'll pull out of your community." Essentially we're blackmailed into suspending all manner of reasonable judgment – to believe that a sudden jump in premiums over the last two years is caused by anything other than investment company losses. In fact, it typically takes five years for a malpractice case to work its way through the system.

It would be a travesty of justice for Congress and state legislatures to take away patients' legal rights in the name of protecting insurance company profits and doctors' income. Caps on damages hurt those most seriously injured. The fact is that the legal system is all patients have to ensure just compensation for injury and to force improvements in patient safety. It's clear that the current regulatory system is not up to the task.

Our goal in issuing this briefing book is not just to refute the phony charges. The underlying problem of sloppy medical care urgently needs to be addressed. Doctors and hospitals have been able to shift the costs of their carelessness onto victims. This "compensation gap" has allowed the medical community to ignore the problem of medical errors.

It is very unfortunate that rather than reducing the real threats that current medical care poses to their patients, the doctor's lobby has proposed to shift the costs of injuries onto innocent individuals, their families, voluntary organizations and taxpayers. Doctors, patients and consumers should be allies on this issue – which fundamentally comes down to improving the quality of medical care in the U.S. – not be pitted against each other.

# Doctors' Attacks on the Tort System Are a Misdiagnosis that Diverts Attention from an Epidemic of Medical Errors and Unsafe Practices

- **Between 44,000 to 98,000 Americans die in hospitals each year due to *preventable* medical errors, according to the Institute of Medicine.**[1] By comparison the annual death toll from automobile accidents is 43,000, 42,000 die from breast cancer and 15,000 die from AIDS. The IOM estimates the costs to society for these medical errors at $17 billion to $29 billion. These costs include disability and health care costs, lost income, lost household production and the personal costs of care. These figures do not take account of medical malpractice occurring outside the hospital setting.

- **Medical journals, state reporting systems and news accounts document continuing, widespread disregard for patient safety.**

  *Hospital infections.* The *Chicago Tribune* reported that some 75,000 Americans die each year because of infections acquired in hospitals that "were preventable, the result of unsanitary facilities, germ-laden instruments, unwashed hands and other lapses."[2]

  *Medication errors.* Two recent studies have found numerous errors in administering medication to hospitalized patients. An Auburn University study of 36 hospitals and nursing homes in Colorado and Georgia found that on average, 19 percent of medication doses were given in error, with 7 percent judged to be potentially harmful.[3] The authors said this amounts to about 40 potential adverse drug events per day in a typical 300-patient facility.

  *Wrong-patient surgery.* According to a study published in the *Annals of Internal Medicine*, New York hospitals reported 27 instances of invasive procedures performed on the wrong patient between April 1998 and December 2001.[4] (There were nine such instances in Florida in 2001.[5]) In trying to determine how such shocking errors could occur, the New York researchers analyzed one case in detail. The case study determined that medical personnel had ignored "many seemingly clear signals that they were subjecting the wrong patient to an invasive procedure."

- **The resources devoted to preventing medical errors are disproportionate to their toll in lives.** Deaths attributable to medical errors each year exceed those caused by breast cancer and AIDS. Yet while the federal government spends $655 million on breast cancer prevention[6] and $3.5 billion on AIDS prevention,[7] only about $130 million has been committed this year, for the first time, for improving patient safety.[8]

- **Physicians' cavalier attitudes toward medical errors are out of step with public opinion.** The *New England Journal of Medicine* recently released a survey of physicians and the public on the issue of medical errors.[9] The public understands this problem far better than do physicians. The public is more likely than physicians to agree with patient safety experts' assessments of how to reduce medical errors. The public understands the need for

better nurse staffing. The public understands the role of fatigue in causing injuries to patients. The public wants hospitals to develop patient safety systems. The public wants computerized prescriptions and medical records. The public wants mandatory reporting of medical errors. The public wants stronger disciplining of doctors. On each of these issues, doctors are in significant disagreement with the public and with the experts.

- **Doctors' views on accountability for medical errors are out of step with the public's.** The respondents to the (*New England Journal of Medicine*) survey were given a hypothetical case of a doctor ordering the use of an antibiotic for a patient whose medical record noted an allergy, and who subsequently died. The vast majority of the lay respondents to this survey thought that such a doctor should be held accountable, both through a malpractice lawsuit and through disciplinary proceedings. Significantly fewer doctors felt the same. Doctors are promoting an approach to public policy with which the general public simply does not agree with.

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[1] Institute of Medicine, To Err Is Human: Building a Safer Health System, November, 1999.
[2] Berens, "Infection Epidemic Carves Deadly Path," *Chicago Tribune*, July 21, 2002. This number is attributed to the "Tribune's analysis, which adopted methods commonly used by epidemiologists."
[3] Barker et al, "Medication Errors Observed in 36 Heath Care Facilities," 162 Arch Intern Med. 1897 (2002).
[4] Chassin & Becher, "The Wrong Patient," 136 Ann Intern Med. 826 (2002).
[5] Agency for Health Care Administration, *Risk Management Reporting Summary*, March 2002.
[6] "Fiscal Year 2003 Defense Appropriations Conference Summary Of Agreements," Committee on Appropriations, October 9, 2002. See also: http://216.239.53.100/search?q=cache:azyKTgpXKNEC:www.house.gov/appropriations/news/107_2/03defconf.htm+%22breast+cancer%22+FY+2002+budget+&hl=en&ie=UTF-8
[7] Kaiser Family Foundation, *Federal HIV/AIDS Spending: A Budget Chartbook*, 2001.
[8] *HHS Announces $50 Million Investment to Improve Patient Safety*. Press Release, October 11, 2001. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/news/press/pr2001/patsafpr.htm; Phone conversation with Veterans Health Administration FOIA Officer, Clay Johnson, December 19, 2002; Phone conversation with Agency for Healthcare Research and Quality Public Inquiries Officer, Paula Hunt, December 19, 2002.
[9] *Views of Practicing Physicians and the Public on Medical Errors*, The New England Journal of Medicine, 347:1933-1944 (Dec. 12, 2002).

## Rather than Facing "Runaway Litigation," Doctors Benefit from a Claims Gap

- **The landmark Harvard Medical Practice Study found that only a small percentage of medical errors result in lawsuits.** Twelve years ago, Harvard researchers using a sample of hospitalizations in New York State compared medical records to claims files. They found that only one in eight medical errors committed in hospitals results in a malpractice claim.[1] Researchers replicating this study made similar findings in Colorado and Utah.[2] [See figure "Malpractice Claims Gap: Ratio of Medical Errors to Claims Filed."]

- **Actual numbers collected by government agencies show a similar claims gap.** A Florida statute requires hospitals to report "adverse incidents," defined as "an event over which health care personnel could exercise control" that results in death or injury. Tables prepared by Florida's Agency for Health Care Administration have compared reports of adverse incidents to filing of new malpractice claims. From 1996 through 1999, Florida hospitals reported 19,885 incidents but only 3,177 medical malpractice claims.[3] In other words, for every 6 medical errors only 1 claim is filed. [See figure "Florida Malpractice Claims Gap: 1996-1999 Ratio of Medical Errors to Claims Filed.".]

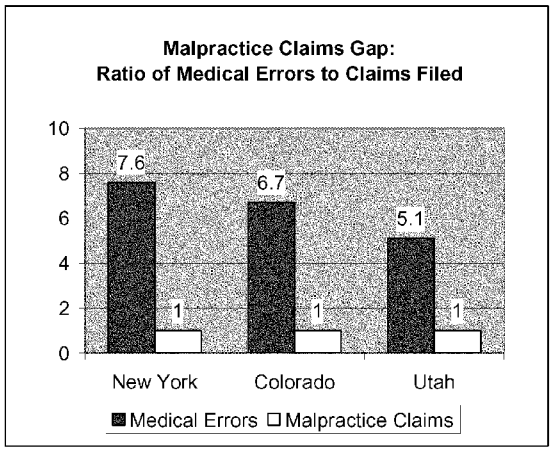
- **By any measure, it is clear that the number of medical errors far outstrips the number of lawsuits.** On hospital discharge forms, health information management specialists are asked to record an "external cause of injury," or "E-code" for a patient. A number of codes correspond to "medical misadventures" during surgical and medical care. [4] Public Citizen obtained E-Code information from those states that collect such data and will supply it either for free or for less than $100. In each of the states for which we were able to obtain accurate data, medical injuries outnumbered compensation payments to injured patients by ratios similar to those found by academic researchers. [See figure "Malpractice Compensation Gap: Hospital E-Code Injuries vs. Malpractice Payments."]

- **Overall tort expenditures are less than the cost of medical injuries.** Because so few medical injuries result in compensation to patients, the overall expenditures made for medical liability are far below the projected injury costs. The Institute of Medicine estimated the costs of preventable medical injuries in hospitals alone at between $17 billion and $29 billion.[5] The Utah Colorado Medical Practice study estimated it at $20 billion.[6] By contrast, the National Association of Insurance Commissioners reports that the total amount spent on medical malpractice insurance in 2000 was $6.4 billion.[7] This is at least three to five times less than the cost of malpractice to society. [See figure "Malpractice Compensation Gap: Annual Costs of Medical Negligence vs. Medical Liability Expenditures."]

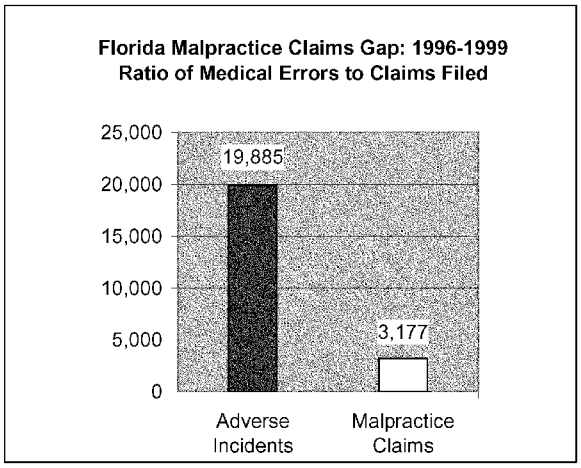
- **Malpractice insurance costs amount to only 3.2 percent of the average physician's revenues.** According to experts at the federal government's Medicare Payment Advisory Commission (MedPAC), who have no axe to grind about medical liability, liability insurance premiums make up just a tiny part of a physician's expenses and have increased by only 4.4 percent over the last year.[8] The increase in this expense is noticeable primarily because of the decreases in reimbursements that doctors are receiving from HMOs and government health programs.

- **The compensation gap helps explain why, although medical injuries are costly, expenditures on medical liability comprise less than one percent of overall health care costs.** As the Congressional Budget Office reported, "Malpractice costs account for a very small fraction of total health care spending; even a very large reduction in malpractice costs would have a relatively small effect on total health plan premiums. In addition, some of the savings leading to lower medical malpractice premiums—those savings arising from changes in the treatment of collateral-source benefits—would represent a shift in costs from medical malpractice insurance to health insurance."[9]

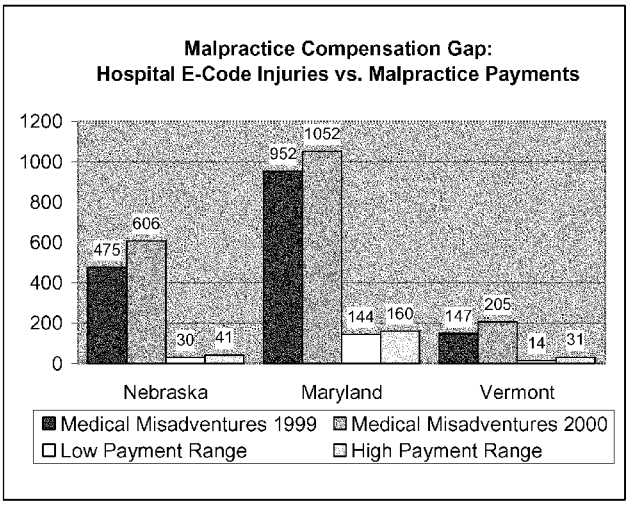
[1] Harvard Medical Practice Study Group, Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York (1990).
[2] Studdert et al, "Beyond Dead Reckoning: Measures of Medical Injury Burden, Malpractice Litigation, and Alternative Compensation Models from Utah and Colorado," 33 Ind. L. Rev. 1643 (2000).
[3] The Agency for Health Care Administration; Division of Health Quality Assurance. Reported malpractice claims by district compared to reported adverse incidents 1996, 1997, 1998, 1999.
[4] Adverse events characterized as "misadventures" include accidental cuts during surgery, foreign objects left in a patient during surgery, infections caused by failure of sterile precautions, and performance of inappropriate operations. They do not include abnormal reactions and other complications that occur during medical care. A misadventure does not necessarily constitute "medical negligence," which is a legal term of art. However, a "misadventure" would constitute malpractice if it was a deviation from the standard of care and resulted in more than momentary harm to a patient.
[5] Institute of Medicine, To Err is Human (2000).
[6] Studdert et al supra note 2.
[7] NAIC, *Statistical Compilation of Annual Statement Information for Property/Casualty Insurance Companies in 2000* (2001).
[8] Official Transcript, Medicare Payment Advisory Commission, Public Meeting, December 12, 2002.
9 Congressional Budget Office Cost Estimate, H.R. 4600, September 24, 2002.



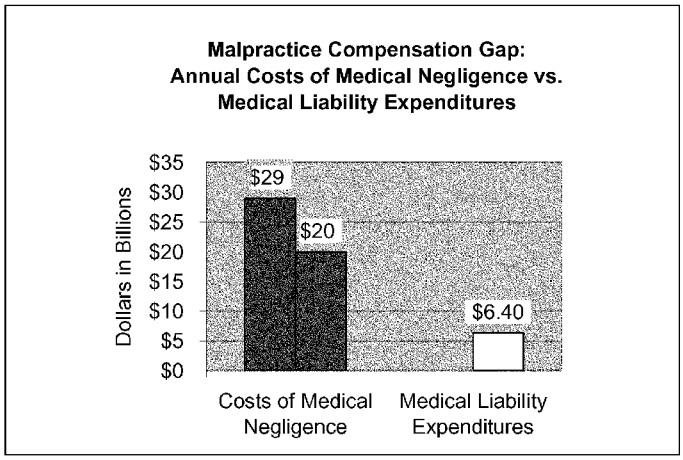

Source: Harvard Medical Practice Study Group, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York* (1990); Studdert et al, "Beyond Dead Reckoning: Measures of Medical Injury Burden, Malpractice Litigation, and Alternative Compensation Models from Utah and Colorado," 33 Ind. L. Rev. 1643 (2000).




Source: The Agency for Health Care Administration; Division of Health Quality Assurance. Reported malpractice claims by district compared to reported adverse incidents 1996, 1997, 1998, 1999.




Source: Nebraska Department of Health and Human Services, Maryland Health Services Cost Review Commission, Vermont Department of Health Statistics, National Practitioner Data Bank.




Source: Institute of Medicine, To Err is Human (2000); Studdert et al, "Beyond Dead Reckoning Measures of Medical Injury Burden, Malpractice Litigation, and Alternative Compensation Models from Utah and Colorado," 33 Ind. L. Rev. 1643 (2000). NAIC, *Statistical Compilation of Annual Statement Information for Property/Casualty Insurance Companies in 2000* (2001).

# The Costs of Medical Malpractice to Patients and Consumers Versus the Cost to Doctors

The Institute of Medicine has estimated that from 44,000 to 98,000 Americans die in hospitals every year from *preventable* medical errors. The IOM also estimates that these errors cost society $17 billion to $29 billion per year. These costs include disability and health care costs, lost income, lost household production and the personal costs of care. They do not include the costs of medical malpractice that occurs outside the hospital setting. The table below compares these costs, prorated on a state-by-state basis, to the amount that physicians pay in medical malpractice premiums in those states. The costs of medical malpractice to society dwarf the costs to doctors.

| State | Preventable Deaths Due to Medical Errors Each Year* | Costs Resulting from Preventable Medical Errors Each Year* (Millions) | Doctors' Medical Malpractice Premiums Paid in 2000** (Millions) |
|---|---|---|---|
| Alabama | 695 – 1,549 | $269 – $458 | $100.0 |
| Alaska | 98 – 218 | $38 – $65 | $12.4 |
| Arizona | 802 – 1,787 | $310 – $529 | $131.0 |
| Arkansas | 418 – 931 | $161 – $275 | $35.9 |
| California | 5,296 – 11,795 | $2,046 – $3,490 | $609.7 |
| Colorado | 672 – 1,498 | $260 – $443 | $83.8 |
| Connecticut | 532 – 1,186 | $206 – $351 | $106.1 |
| Delaware | 123 – 273 | $47 – $81 | $17.8 |
| District of Columbia | 89 – 199 | $35 – $59 | $36.0 |
| Florida | 2,499 – 5,566 | $965 – $1,647 | $505.5 |
| Georgia | 1,280 – 2,851 | $495 – $844 | $183.3 |
| Hawaii | 189 – 422 | $73 – $125 | $29.9 |
| Idaho | 202 – 451 | $78 – $133 | $20.1 |
| Illinois | 1,942 – 4,325 | $750 – $1,280 | $393.0 |
| Indiana | 951 – 2,117 | $367 – $627 | $51.6 |
| Iowa | 458 – 1,019 | $177 – $302 | $54.6 |
| Kansas | 420 – 936 | $162 – $277 | $43.2 |
| Kentucky | 632 – 1,407 | $244 – $416 | $65.3 |
| Louisiana | 699 – 1,556 | $270 – $461 | $76.0 |
| Maine | 199 – 444 | $77 – $131 | $26.0 |
| Maryland | 828 – 1,844 | $320 – $546 | $148.3 |
| Massachusetts | 993 – 2,211 | $384 – $654 | $158.8 |
| Michigan | 1,554 – 3,461 | $600 – $1,024 | $173.3 |
| Minnesota | 769 – 1,713 | $297 – $507 | $50.0 |
| Mississippi | 445 – 991 | $172 – $293 | $35.35 |
| Missouri | 875 – 1,948 | $338 – $577 | $108.4 |

| State | Preventable Deaths Due to Medical Errors Each Year* | Costs Resulting from Preventable Medical Errors Each Year* (Millions) | Doctors' Medical Malpractice Premiums Paid in 2000** (Millions) |
|---|---|---|---|
| Montana | 141 – 314 | $54 – $93 | $16.3 |
| Nebraska | 268 – 596 | $103 – $176 | $24.6 |
| Nevada | 312 – 696 | $121 – $206 | $50.8 |
| New Hampshire | 193 – 430 | $75 – $127 | $17.3 |
| New Jersey | 1,316 – 2,930 | $508 – $867 | $307.4 |
| New Mexico | 284 – 633 | $110 – $187 | $27.1 |
| New York | 2,967 – 6,608 | $1,146 – $1,955 | $857.1 |
| North Carolina | 1,259 – 2,803 | $486 – $829 | $126.5 |
| North Dakota | 100 – 224 | $39 – $66 | $12.8 |
| Ohio | 1,775 – 3,954 | $686 – $1,170 | $239.8 |
| Oklahoma | 540 – 1,202 | $208 – $356 | $57.7 |
| Oregon | 535 – 1,191 | $207 – $353 | $40.9 |
| Pennsylvania | 1,920 – 4,277 | $742 – $1,266 | $325.8 |
| Rhode Island | 164 – 365 | $63 – $108 | $21.8 |
| South Carolina | 627 – 1,397 | $242 – $413 | $18.8 |
| South Dakota | 118 – 263 | $46 – $78 | $10.5 |
| Tennessee | 890 – 1,981 | $344 – $586 | $179.3 |
| Texas | 3,260 – 7,261 | $1,260 – $2,149 | $352.8 |
| Utah | 349 – 778 | $135 – $230 | $36.1 |
| Vermont | 95 – 212 | $37 – $63 | $9.1 |
| Virginia | 1,107 – 2,465 | $428 – $729 | $120.8 |
| Washington | 922 – 2,053 | $356 – $607 | $109.9 |
| West Virginia | 283 – 630 | $109 – $186 | $62.7 |
| Wisconsin | 839 – 1,868 | $324 – $553 | $59.5 |
| Wyoming | 77 – 172 | $30 – $51 | $10.3 |
| | ***Total Premiums Paid*** | | **$6,351.05** |

Sources:

* The range of preventable deaths and costs resulting from medical errors are prorated based on each state's share of overall U.S. population in 2000. Population statistics for 2000 from Census Bureau. Preventable deaths and costs data from, To Err is Human: Building a Safer Health System, Institute of Medicine, 1999.

** *Statistical Compilation of Annual Statement Information for Property/Casualty Insurance Companies in 2000*, National Association of Insurance Commissioners.

## Increases in Medical Malpractice Premiums and Payments Track — and Do not Exceed Increased Costs of Injuries

- **Government data shows that medical malpractice awards have increased at a much slower pace than claimed by Jury Verdict Research.** According to the federal government's National Practitioner Data Bank (NPDB), the median medical malpractice payment by a physician to a patient rose 35 percent from 1997 to 2001, from $100,000 to $135,000.[1] By contrast, data from Jury Verdict Research (JVR), a private research firm, shows that awards rose 100 percent from 1997 to 2000, from $503,000 to $1 million.[2] The reasons for the huge difference: JVR only collects jury *verdict* information that is reported to it by attorneys, court clerks and stringers. The NPDB is the most comprehensive source of information that exists because it includes both verdicts *and* settlements. Ninety-six percent of all medical malpractice cases are settled, as opposed to decided by a jury, and settlements result in much lower awards than jury verdicts.

- **Malpractice insurance costs have risen at half the rate of medical inflation, debunking the myth of "out-of-control juries."** At a July 2002 congressional hearing, Dr. Richard Anderson of The Doctors Company complained that "since 1990, [malpractice] claims costs have risen annually by 6.9 percent, nearly three times the rate of inflation."[3] The appropriate comparison is to health care inflation, because the bulk of damage awards go to pay medical bills.[4] But while medical costs have increased by 113 percent since 1987, the total amount spent on medical malpractice insurance has increased by just 52 percent over that time—less than half of medical services inflation.[5] [See figure "Medical Care Services Inflation vs. Growth in Malpractice Written Premiums."]

- **Government data shows that medical malpractice awards have increased at a slower pace than health insurance premiums.** According to the federal government's National Practitioner Data Bank, the median medical malpractice payment by a physician to a patient rose 35 percent from 1997 to 2000, from $100,000 to $135,000.[6] But during the same time, the average premium for single health insurance coverage has increased by 39 percent.[7] [See Figure, "Growth in Health Insurance Costs and Malpractice Awards Compared."] Payments for health care costs, which directly affect health insurance premiums, make up the lion's share of most medical malpractice awards.

- **Medical malpractice awards are increasing in line with other general social trends.** In addition to medical costs, malpractice awards include two other main elements, lost wages and pain and suffering. These, like medical costs, are in turn multiplied by life expectancy. All of these factors are affected by upward social trends. Juries have not changed their behavior, but the numbers jurors take into account in making awards have changed.

- **Increases in our standard of living lead to higher awards.** Median household income has risen by an average of about $1,000 each year, more than doubling over the past 20 years from $17,710 in 1980 to $42,151 in 2000.[8] This increase reflects not only inflation but also real increases in our affluence. Higher expectations about quality of life affect the

valuation placed on a victim's pain and suffering. In years past, sickness and injury were viewed as an inevitable part of life. Today, health and safety are taken for granted, and most Americans expect to live a long, healthy life. Americans place a greater value on physical activity; the International Health, Racquet, and Sportsclub Association reports that health club memberships are increasing at a 9 percent annual rate.[9] It is more likely today that a plaintiff will have regularly engaged in recreational or other physical activities, making a disabling injury all the more severe.

- **Increased life expectancy leads to higher awards**. According to the Center for Disease Control and Prevention, since 1980 the average life expectancy in the United States has increased by three years, from 73.7 to 76.7 years.[10] The retirement age, set by Social Security, has also increased, resulting in longer expected years of employment. The full retirement age is 65 for persons born before 1938. The age gradually rises until it reaches 67 for persons born in 1960 or later.[11]

[1] National Practitioner Data Bank Annual Reports, 1997 through 2001.
[2] Jury Verdict Research, "Medical Malpractice: Verdicts, Settlements and Statistical Analysis," 2002.
[3] Statement of Richard Anderson Before House Energy and Commerce Committee, July 17, 2002.
[4] Institute of Medicine, *To Err is Human* (2000).
[5] Office of the West Virginia Insurance Commission, *Medical Malpractice: Report on Insurers with over 5% Market Share* (November 2002)
[6] National Practitioner Data Bank Annual Reports, 1997 through 2001.
[7] Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits Surveys, 1998-2002; National Practitioner Data Bank Annual Reports, 1997 through 2001.
[8] Table H-7. Divisions—Households (All Races) by Median and Mean Income, 1976 to 2000. U.S. Census Bureau.
[9] http://www.ihrsa.org/industrystats/opbenchmarks.html
[10] Table 12. Estimated life expectancy at birth in years, by race and sex, National Vital Statistics Report, Vol. 50, No.6, March 21, 2002. www.cdc.gov
[11] www.ssa.gov

## Medical Care Services Inflation vs. Growth in Malpractice Written Premiums

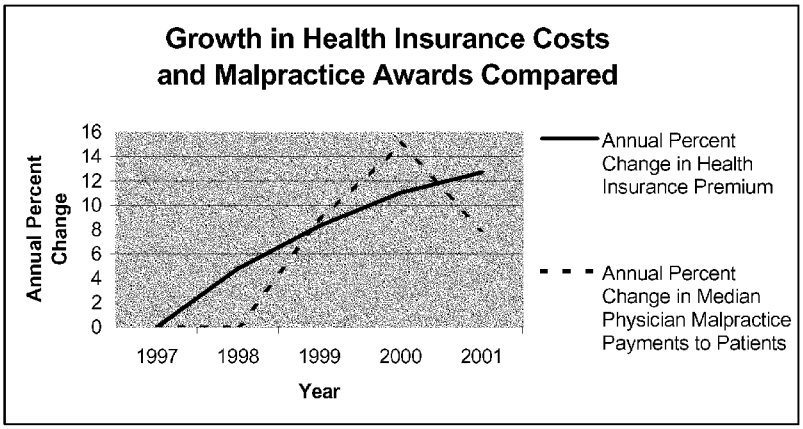
| Year | CPI-U Index | Annual Percent Change | Cumulative Percent Change | Industry MedMal Net Written Premiums (000's) | Annual Percent Change | Cumulative Percent Change |
|---|---|---|---|---|---|---|
| 1987 | 130.4 | – | – | 4,004,185 | – | – |
| 1988 | 139.0 | 6.6% | 6.6% | 4,027,825 | 0.6% | 0.6% |
| 1989 | 147.9 | 6.4% | 13.4% | 4,278,009 | 6.2% | 6.8% |
| 1990 | 161.5 | 9.2% | 23.8% | 4,014,622 | -6.2% | 0.3% |
| 1991 | 176.1 | 9.0% | 35.0% | 4,067,803 | 1.3% | 1.6% |
| 1992 | 189.7 | 7.7% | 45.5% | 4,133,567 | 1.6% | 3.2% |
| 1993 | 202.6 | 6.8% | 55.4% | 4,370,812 | 5.7% | 9.2% |
| 1994 | 212.6 | 4.9% | 63.0% | 4,780,537 | 9.4% | 19.4% |
| 1995 | 223.5 | 5.1% | 71.4% | 4,800,552 | 0.4% | 19.9% |
| 1996 | 231.9 | 3.8% | 77.8% | 4,875,486 | 1.6% | 21.8% |
| 1997 | 238.7 | 2.9% | 83.1% | 4,892,496 | 0.3% | 22.2% |
| 1998 | 246.5 | 3.3% | 89.0% | 5,145,066 | 5.2% | 28.5% |
| 1999 | 254.6 | 3.3% | 95.2% | 5,104,093 | -0.8% | 27.5% |
| 2000 | 265.6 | 4.3% | 103.7% | 5,586,584 | 9.5% | 39.5% |
| 2001 | 278.3 | 4.8% | 113.4% | 6,072,468 | 8.7% | 51.7% |
| 2002 | 291.7 | 4.8% | 123.7% | – | – | – |

Sources: Bureau of Labor Statistics – Medical Services CPI; Best's Aggregates and Averages.

## Growth in Health Insurance Costs and Malpractice Awards Compared

| Year | Cost of Health Insurance Premium | Annual Percent Change | Median Physician Malpractice Payment to Patient | Annual Percent Change |
|---|---|---|---|---|
| **1997** | $2,196 | *** | $100,000.00 | *** |
| **1998** | $2,268 | 4.8 | $100,000.00 | 0 |
| **1999** | $2,424 | 8.3 | $108,675.00 | 8.7 |
| **2000** | $2,650 | 11.0 | $125,000.00 | 15.0 |
| **2001** | $3,060 | 12.7 | $135,000.00 | 8.0 |
| ***Cumulative Change*** | | **39%** | ***Cumulative Change*** | **35%** |

Sources: Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits Surveys, 1998-2002. National Practitioner Data Bank Annual Reports, 1997 through 2001.



## The Spike in Medical Liability Premiums Was Caused by the Insurance Cycle, Not by "Skyrocketing" Jury Verdicts

- **For much of the 1990s, doctors benefited from artificially lower premiums.** According to the International Risk Management Institute (IRMI), one of the leading analysts of commercial insurance issues, "What is happening to the market for medical malpractice insurance in 2001 is a direct result of trends and events present since the mid to late 1990s. Throughout the 1990s, and reaching a peak around 1997 and 1998, insurers were on a quest for market share, that is, they were driven more by the amount of premium they could book rather than the adequacy of premiums to pay losses. In large part this emphasis on market share was driven by a desire to accumulate large amounts of capital with which to turn into investment income." IRMI also noted: "Clearly a business cannot continue operating in that fashion indefinitely."[1]

- **West Virginia Insurance Commissioner blames the market.** According to the Office of the West Virginia Insurance Commission (one of the states in the throes of a medical malpractice "crisis"), "[T]he insurance industry is cyclical and necessarily competitive. We have witnessed these cycles in the Medical Malpractice line in the mid-'70's, the mid-80's and the present situation. This particular cycle is, perhaps, worse than previous cycles as it was delayed by a booming economy in the '90's and is now experiencing not just a shortfall in rates due to competition, but a subdued economy, lower interest rates and investment yields, the withdrawal of a major medical malpractice writer and a strong hardening of the reinsurance market. Rates will, at some point, reach an acceptable level to insurers and capital will once again flow into the Medical Malpractice market."[2]

- **Medical liability premiums track investment results.** J. Robert Hunter, one of the country's most knowledgeable insurance actuaries and director of insurance for the Consumer Federation of America, recently analyzed the growth in medical liability premiums.[3] He found that premiums charged do not track losses paid, but instead rise and fall in concert with the state of the economy. When the economy is booming and investment returns are high, companies maintain premiums at modest levels; however, when the economy falters and interest rates fall, companies increase premiums in response.

- **The same trends are present in other lines of insurance.** Property/casualty refers to a large group of liability lines of insurance (30 in total) including medical malpractice, homeowners, commercial, and automobile. The property/casualty insurance industry has exhibited cyclical behavior for many years, as far back as the 1920s. These cycles are characterized by periods of rising rates leading to increased profitability. Following a period of solid but not spectacular rates of return, the industry enters a down phase where prices soften, supply of the insurance product becomes plentiful, and, eventually, profitability diminishes, or vanishes completely. In the down phase of the cycle, as results deteriorate, the basic ability of insurance companies to underwrite new business or, for some companies even to renew some existing policies, can be impaired. This is because the capital needed to support the underwriting of risk has been depleted through losses. The current market began

to harden in 2001, following an unusually prolonged period of soft market conditions in the property-casualty section in the 1990s. The current hard market is unusual in that many lines of insurance are affected at the same time, including medical malpractice. As a result, premiums are rising for most types of insurance. The increases have taken policyholders by surprise given that they came after several years of relatively flat to decreasing prices.[4]

- **Insurer mismanagement compounded the problems.** Compounding the impact of the cycle has been misleading accounting practices. As the *Wall Street Journal* found in a front page investigative story on June 24, 2002, "[A] price war that began in the early 1990s led insurers to sell malpractice coverage to obstetrician-gynecologists at rates that proved inadequate to cover claims. Some of these carriers had rushed into malpractice coverage because an accounting practice widely used in the industry made the area seem more profitable in the early 1990s than it really was. A decade of short-sighted price slashing led to industry losses of nearly $3 billion last year."[5] Moreover, "In at least one case, aggressive pricing allegedly crossed the line into fraud." According to Donald J. Zuk, chief executive of SCPIE Holdings Inc., a leading malpractice insurer in California, "Regardless of the level of … tort reform, the fact remains that if insurance policies are consistently under-priced, the insurer will lose money."[6]

- **There is no growth in the number of new medical malpractice claims.** According to the National Association of Insurance Commissioners (NAIC), the number of new medical malpractice claims declined by about four percent between 1995 and 2000. There were 90,212 claims filed in 1995; 84,741 in 1996; 85,613 in 1997; 86,211 in 1998; 89,311 in 1999; and 86,480 in 2000.[7]

[1] Kolodkin, Charles, "Medical Malpractice Insurance Trends? Chaos!" International Risk Management Institute. http://www.irmi.com/expert/articles/kolodkin001.asp

[2] State of West Virginia Medical Malpractice Report on Insurers with over 5% Market Share, Provided by the Office of the West Virginia Insurance Commission, November 2002.

[3] Americans for Insurance Reform, "Medical Malpractice Insurance: Stable Losses/Unstable Rates," October 10, 2002. See also: http://www.insurance-reform.org/StableLosses.pdf.

[4] Hot Topics & Insurance Issues, Insurance Information Institute, www.iii.org

[5] Christopher Oster and Rachel Zimmerman,"Insurers' Missteps".
Helped Provoke Malpractice 'Crisis,'" *Wall Street Journal* , June 24, 2002.

[6] Charles Kolodkin, Gallagher Healthcare Insurance Services, "Medical Malpractice Insurance Trends? Chaos!" ((September 2001), found at http://www.irmi.com/expert/articles/kolodkin001.asp.

[7] National Association of Insurance Commissioners, Statistical Compilation of Annual Statement Information for Property/Casualty Insurance Companies in 2000 (2001).

# "Repeat Offender" Physicians Are Responsible for the Bulk of Medical Malpractice Costs

- **Five percent of doctors are responsible for 54 percent of malpractice in the U.S.** Public Citizen's analysis of the National Practitioner Data Bank, which covers malpractice judgments and settlements since September 1990, found that 5.1 percent of doctors (35,009) have paid two or more malpractice awards to patients. These doctors are responsible for 54 percent of all payouts reported to the Data Bank. Of these, only 7.6% have ever been disciplined by state medical boards. Only 17 percent of doctors (1 out of 6) who have made 5 or more malpractice payouts have been disciplined.[1]

- **A Vanderbilt University study found that doctors with past records of malpractice claims can be expected to have "appreciably worse claims experience" than other doctors in future years.**[2] Despite the fact that claims history predicts future claims, neither licensing boards nor the insurance market have been effective in reducing malpractice. There are over 6,000 doctors in the U.S. who have paid *four* or more malpractice claims, amounting to $6.5 billion. These numbers can be expected to grow.

- **Redacted records from the National Practitioner Data Bank demonstrate that lax discipline by medical boards allows questionable doctors to inflict repeated injuries on patients:**

  Physician Number 94358, licensed in New Jersey, settled or lost 33 medical malpractice suits involving improper diagnosis or treatment between 1988 and 1993, inflicting over $400,000 in disability costs to his patients. This doctor has not been disciplined by authorities in New Jersey.

  Physician Number 64625, licensed in Pennsylvania, paid 24 medical malpractice claims involving improper performance of surgery between 1989 and 2001. Damages to this doctor's patients exceeded $370,000. This doctor has never been disciplined by Pennsylvania authorities.

  Physician Number 125457, while licensed in Nevada, paid five malpractice claims involving improper performance of surgery between 1995 and 1997, with damages totaling $2.3 million. Recent news accounts have reported that doctors are fleeing from Las Vegas to other states to avoid high malpractice insurance premiums. Physician 125457 was ahead of the curve in moving his practice to California. There he paid another eight malpractice claims with damages exceeding $7.5 million. This doctor has never been disciplined by authorities in either Nevada or California.

  Physician Number 37949, licensed in Texas, settled or lost 13 medical malpractice suits involving improper treatment or improper performance of surgery between 1990 and 1997. Two of the suits involved the same allegation—a foreign body left in the patient during surgery. Damages to this doctor's patients exceeded $2 million. This doctor has never been disciplined by authorities in Texas.

[1] National Practitioner Data Bank, Sept. 1, 1990 – Sept. 30, 2002.
[2] Sloan et al, "Medical Malpractice Experience of Physicians: Predictable or Haphazard?" 262 JAMA 3291 (1989)

## Few, If Any, Malpractice Lawsuits Are "Frivolous"

- **The contingency fee system discourages attorneys from bringing frivolous claims.** Medical malpractice cases are brought on a contingency fee basis, meaning the attorney receives payment only in the event there is a settlement or verdict. If the claim is closed without payment, the attorney does not receive a fee. Since attorneys must earn money to stay in business, it follows that they would not intentionally take on a non-meritorious case.

- **The high cost of preparing a medical malpractice case discourages frivolous claims—and meritorious claims as well.** Medical malpractice cases are very expensive for plaintiffs' attorneys to bring, with out-of-pocket costs for cases settled at or near the time of trial (when most cases are settled) ranging from $15,000 to $25,000.[1] If the case goes to trial, the costs can easily be doubled.[2] These costs do not include the plaintiff's attorney's time, and an attorney pursuing a frivolous case incurs opportunity costs in not pursuing other cases. An attorney incurs expenses beginning with the determination of whether a case has merit. First, the attorney is required to obtain copies of the patient's medical records from all the providers for analysis by a competent medically trained person. If that initial consultation reveals a likelihood of medical negligence, the records must then be submitted to medical specialists, qualified to testify in court, for final review. Typically, the records must be sent to experts outside of the plaintiff's state, as physicians within the state will refuse to testify against local colleagues. As a result, the experts who agree to review records and testify can and do charge substantial fees. Fees from $1,000 per hour to several thousand dollars are not uncommon.[3] Discovery involves taking the sworn testimony of witnesses and experts. Such depositions cost $300 and up, depending upon their length and complexity. If an expert witness is deposed, the plaintiff's attorney is charged for the witness' preparation time and time attending the deposition.

- **Plaintiffs drop 10 times more claims than they pursue**. The Physician Insurers Association of America (PIAA) reports that between 1985 and 2001 a total of 108,300 claims were "dropped, withdrawn or dismissed." This is 63 percent of the total number of claims (172,474) closed during the study period.[4] It is unclear what portion constitutes involuntarily dismissed cases (dismissed after a motion was filed by the defendant) rather than cases voluntarily dismissed by plaintiffs. According to researchers at the University of Washington School of Medicine, about nine percent of claims files are closed after the defendant wins a contested motion[5] Based on this figure, Public Citizen estimates that about 54 percent of claims are being abandoned by patients.[6] An attorney may send a statutorily-required notice of intent to claim or file a lawsuit in order to meet the requirements of the statute of limitations but, after collecting medical records and consulting with experts, decide not to pursue the claim. We estimate that the number of cases withdrawn voluntarily by plaintiffs[7] was 92,621, *10 times* the number of cases that were taken to trial and lost during that period (9,293). The percentage of claims pursued by plaintiffs to final rejection by a jury is only *five percent*.[8]

- **The small number of claims pursued to a defense verdict are not frivolous.** Researchers at the American Society of Anesthesiologists arranged for pairs of doctors to review 103 randomly selected medical negligence claims files.[9] The doctors were asked to judge whether the anesthesiologist in question had acted reasonably and prudently. The doctors only agreed on the appropriateness of care in 62 percent of the cases; they disagreed in 38 percent of cases. The researchers concluded, "These observations indicate that neutral experts (the reviews were conducted in a situation that did not involve advocacy or financial compensation) commonly disagree in their assessments when using the accepted standard of reasonable and prudent care." The percentage of all medical malpractice claims that go to trial is only 6.6 percent, according to PIAA, meaning that the parties and their attorneys ultimately reach agreement about liability five times more often than neutral doctors do. If truly frivolous lawsuits were being pursued, the proportion of claims going to trial would exceed the 38 percent of claims on which even doctors will disagree.

- **The costs of defending claims that are ultimately dropped are not unreasonable.** Medical liability insurers have complained about the costs of defending cases that are ultimately dropped. But the professional obligation of lawyers to exercise due diligence is essentially identical to the duty of physicians. The lawyer must rule out the possibility of proving medical negligence before terminating a claim, just as doctors must rule out the possibility of illnesses suggested by their patients' symptoms. The doctor performs his duty by administering tests; the lawyer performs hers by using discovery procedures. Both processes can lead to dead ends. But plaintiffs' lawyers have no financial incentive to abuse the litigation process: they are using their own time and money to pursue discovery activities, and are only paid for work on behalf of clients whose cases are successful.

[1] Based on Public Citizen interviews with plaintiff attorneys.
[2] See Vidmar, Medical Malpractice and the American Jury (1995).
[3] According to the Physician Insurers Association of America, expert witnesses in a medical malpractice case are paid on average over $4,800.
[4] *Trend Analysis Report*, 2001 Edition, 6b-4
[5] Rosenblatt & Hurst, "An Analysis of Closed Obstetric Malpractice Claims," 74 *Obstetrics & Gynecology* 710 (1989).
[6] Another study, Sloan et al, *Suing for Medical Malpractice*, (1993) found the number was 5.9 percent, not nine percent. According to our queries to the database of Federal District Court Civil Cases, maintained by Professors Theodore Eisenberg and Kevin Clermont, about 4.7 percent of 10,075 medical malpractice cases between 1987 and 1992 were disposed of by pre-trial motion. To make a conservative estimate, however, we are going to use the nine percent figure.y
[7] .09 times 172,474 equals 15,679; subtracted from 108,300 equals 92,621 claims voluntarily withdrawn.
[8] 9,293/172,474=.054
[9] Posner et al, "Variation in expert opinion in medical malpractice review," 85 *Anesthesiology* 1049 (1996).

# So-Called "Non-Economic" Damages Are Real and Not Awarded Randomly

- **"Non-economic" damages are not as easy to quantify as lost wages or medical bills, but they compensate real injuries.** So-called "non-economic" damages are awarded for the pain and suffering that accompany any loss of normal functions (e.g. blindness, paralysis, sexual dysfunction, lost bowel and bladder control) and inability to engage in daily activities or to pursue hobbies, such as hunting and fishing. This category also encompasses damages for disfigurement and loss of fertility. According to PIAA, the average payment between 1985 and 2001 for a "grave injury," which encompasses paralysis, was only $454,454.

- **No evidence supports the claim that jury verdicts are random "jackpots."** Studies conducted in California, Florida, North Carolina, New York, and Ohio have found that jury verdicts bear a reasonable relationship to the severity of the harm suffered.[1] In total the studies examined more than 3,500 medical malpractice jury verdicts and found a consistent relationship between the severity of the injury and the size of the verdict. Uniformly the authors concluded that their findings did not support the contention that jury verdicts are frequently unpredictable and irrational.

- **The insurance industry's own numbers demonstrate that awards are proportionate to injuries.** PIAA's Data Sharing Report also demonstrates the relationship between the severity of the injury and the size of the settlement or verdict.[2] PIAA, as do most researchers, measures severity of injury according to the National Association of Insurance Commissioners' classifications.[3] The average indemnity paid per file was $49,947 for the least severe category of injury and increased with severity, to $454,454 for grave injuries. All researchers found that the amount of jury verdicts fell off in cases of death, for which the average indemnity was $195,723. This is not surprising, as the costs of medical treatment for a grave injury are likely to be greater and pain and suffering would be experienced over a longer time period than in the case of death.[4]

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[1] Kelso & Kelso, *Jury Verdicts in Medical Malpractice Cases and the MICRA Cap*, Institute for Legislative Practice (1999). Vidmar N, Gross F, Rose M, "Jury Awards for Medical Malpractice and Post-Verdict Adjustments of Those Awards," 48 *DePaul Law Review* 265 (1998). Merritt & Barry, "Is the Tort System In Crisis? New Empirical Evidence," 60 *Ohio State Law Journal* 315 (1999).

[2] *PIAA Data Sharing Report*, Report 7, Part 10.

[3] The NAIC scale grades injury severity as follows:
Emotional damage only (fright; no physical injury);
Temporary insignificant (lacerations, contusions, minor scars);
Temporary minor (infections, fall in hospital, recovery delayed);
Temporary major (burns, surgical material left, drug side-effects);
Permanent minor (loss of fingers, loss or damage to organs);
Permanent significant (deafness, loss of limb, loss of eye, kidney or lung);
Permanent major (paraplegia, blindness, loss of two limbs, brain damage);
Permanent grave (quadriplegia, severe brain damage, lifelong care or fatal prognosis);
Death

[4] Vidmar, Gross, Rose, supra at 284

# Insurance Companies and Their Lobbyists Admit It: Caps on Damages Won't Lower Insurance Premiums

Caps on damages for pain and suffering will significantly lower awards to catastrophically injured patients. But because those truly severe cases make up a small percentage of medical malpractice claims, and because the portion of the medical liability premium dollar that pays for compensation is dwarfed by the portion that pays for defense lawyer fees, caps do not lead to lower premiums. Insurance companies and their lobbyists understand this – so don't take our word for it, take theirs.

### A Premium on the Truth

"Insurers never promised that tort reform would achieve specific savings." – American Insurance Association[1]

"We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates." – Sherman Joyce, president of the American Tort Reform Association[2]

"Many tort reform advocates do not contend that restricting litigation will lower insurance rates, and I've never said that in 30 years." – Victor Schwartz, general counsel to the American Tort Reform Association[3]

### Florida

"No responsible insurer can cut its rates after a bill (that caps damages at $250,000) passes." – Bob White, president of First Professionals Insurance Co.[4]

### Mississippi

"Regardless of what may result from the ongoing tort reform debate, please remember that such proposed public policy changes are critical for the long-term, but do not provide a magical 'silver-bullet' that will immediately affect medical malpractice insurance rates … The 2003 rate change [a 45 percent increase] would happen regardless of the special session outcome." – Medical Assurance Company of Mississippi[5]

### Nevada

"The primary insurer for Las Vegas obstetricians, American Physicians Assurance, has no plans to lower premiums for several years, if ever, said broker Dennis Coffin." – The Las Vegas Review-Journal[6]

"[John Cotton of the Nevada Physicians' Task Force] noted that even if the bill reflected a cap of $5, there would not be an immediate impact on premiums." – Minutes of the Nevada Assembly Committee on Medical Malpractice Issues[7]

### New Jersey

During a hearing on medical malpractice issues, New Jersey Assemblyman Paul D'Amato asked Patricia Costante, Chairwoman and CEO of MIIX Group of Companies, "[A]re you telling the insured physicians in New Jersey that if this State Legislature passes caps that you'll guarantee that you won't raise your premiums, in fact, you'll reduce them?" Costante replied: "No, I'm not telling you [or them] that."[8]

The New Jersey Medical Society commissioned Tillinghast-Towers Perrin, a leading actuarial firm, to analyze the effects of a $250,000 cap on pain and suffering damages. The findings: "We would expect that a $250,000 cap on non-economic damages will produce some savings, perhaps in the 5 percent to 7 percent range for physicians." – Letter from Tillinghast-Towers analysts James Hurley and Gail Tverberg[9]

### Ohio

"In the short run, we may even see prices go up another 20 percent, and people will say, 'Gee, what happened, I thought we addressed this."' – Ray Mazzotta, president of Columbus-based Ohio Hospital Insurance Co.[10]

"The stroke of the governor's pen [enacting caps on damages] will not result in immediate lowering of rates by responsible companies." – Frank O'Neil, spokesman for Birmingham, Ala.-based Medical Assurance[11]

### Wyoming

During a hearing on medical malpractice insurance issues, Bruce Crile of the Doctors' Company and Melissa Dennison of OHIC Insurance Company testified that insurance rates would not drop if caps on damages were imposed. "Both the Doctors' Company and OHIC's actuaries say a cap of $500,000 is meaningless for purposes of ratemaking. Even with caps enacted premiums will still increase, but with predictability of the risk there will be a moderating of rate increases." – Minutes of the Wyoming Legislature's Joint Labor, Health and Social Services Interim Committee[12]

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### Endnotes

[1] "AIA Cites Fatal Flaws In Critic's Report On Tort Reform," American Insurance Association press release, March 13, 2002.
[2] "Study Finds No Link Between Tort Reforms And Insurance Rates," *Liability Week*, July 19, 1999.
[3] Michael Prince, "Tort Reforms Don't Cut Liability Rates, Study Says," *Business Insurance*, July 19, 1999
[4] Phil Galewitz, "Underwriter Gives Doctors Dose of Reality," The Palm Beach Post, January 29, 2003.
[5] Julie Goodman, "Premiums Rise by 45 Percent; Insurance Group's Hike Comes as Doctors Seek Relief," *Clarion-Ledger* (Jackson, Miss.), September 22, 2002.
[6] Joelle Babula, "Obstetricians Say Problems Remain," *The Las Vegas Review-Journal*, October 1, 2002.
[7] "Testimony on Assembly Bill 1: To Make Various Changes Related to Medical and Dental Malpractice," Nevada Assembly Committee on Medical Malpractice Issues, July 30, 2002.
[8] "Testimony Concerning the Affordability of Medical Malpractice Insurance for Physicians Practicing in New Jersey," Public Hearing Before the Assembly Health and Human Services Committee and Banking and Insurance Committee, June 3, 2002.
[9] Letter to Ray Cantor, Director of Governmental Affairs for the State Medical Society of New Jersey, from Tillinghast-Towers analysts James Hurley and Gail Tverberg, January 7, 2003.
[10] "No Drop in Malpractice Rates Pending," The Associated Press, January 10, 2003.
[11] "No Drop in Malpractice Rates Pending," The Associated Press, January 10, 2003.
[12] Testimony at the Wyoming Legislature's Joint Labor, Health and Social Services Interim Committee, December 4-6, 2002.

## Empirical Evidence Does not Confirm the Existence of "Defensive Medicine" — Patient Injuries Refute It

- **A search of the scholarly literature on medicine will turn up dozens of studies documenting the incidence of medical errors, but not one peer-reviewed study documenting purely defensive medicine.** One might laugh at the spectacle of a lobbying campaign constructed around a flimsy theory unsupported by any empirical evidence. Unfortunately, the evidence *disproving* the theory is so overwhelming and compelling as to be truly frightening. Several recent studies demonstrate that current disincentives to unsafe and sloppy practices are inadequate, and show how much more dangerous medical care would be if deterrents were further weakened.

- **The Congressional Budget Office has rejected the defensive medicine theory.** The Congressional Budget Office (CBO) was asked to quantify the savings from reduced "defensive medicine" if Congress passed H.R. 4600. This bill, which contained very stringent restrictions on patients' ability to recover damages, passed the U.S. House in 2002. CBO declined, saying:

  > Estimating the amount of health care spending attributable to defensive medicine is difficult. Most estimates are speculative in nature, relying, for the most part, on surveys of physicians' responses to hypothetical clinical situations, and clinical studies of the effectiveness of certain intensive treatments. Compounding the uncertainty about the magnitude of spending for defensive medicine, there is little empirical evidence on the effect of medical malpractice tort controls on spending for defensive medicine and, more generally, on overall health care spending.
  >
  > A small number of studies have observed reductions in health care spending correlated with changes in tort law, but that research was based largely on a narrow part of the population and considered only hospital spending for a small number of ailments that are disproportionately likely to experience malpractice claims. Using broader measures of spending, CBO's initial analysis could find no statistically significant connection between malpractice tort limits and overall health care spending. Although the provisions of H.R. 4600 could result in the initiation of fewer lawsuits, the economic incentives for individual physicians or hospitals to practice defensive medicine would appear to be little changed.[1]

- **Defensive medicine hasn't prevented wrong-patient surgery.** New York hospitals reported 27 instances of invasive procedures performed on the wrong patient between April 1998 and December 2001.[2] There were nine such instances in Florida in 2001.[3] In trying to determine how such shocking errors could occur, researchers analyzed one case in detail. The case study determined that medical personnel had ignored "many seemingly clear signals that they were subjecting the wrong patient to an invasive procedure." In this case, "defensive medicine" measures would have included follow-up questioning or record-checking when the patient told personnel she had not been admitted for cardiac treatment. Surely if the medical providers were frightened of lawsuits they would have made such minimal inquiries.

- **Defensive medicine hasn't prevented medication errors.** An Auburn University study of 36 hospitals and nursing homes in Colorado and Georgia found that on average, 19 percent of medication doses were given in error, with 7 percent judged to be potentially harmful.[4] The authors said this amounts to about 40 potential adverse drug events per day in a typical 300-patient facility. The errors were made in spite of the presence of observers from the research team—who could easily have been called as witnesses in a medical liability lawsuit. An earlier study by Boston researchers estimated that there are some 500 preventable adverse drug events in the average hospital each year, in spite of the fact that "drug injuries frequently result in malpractice claims, and in a large study of closed claims… accounted for the highest total expenditure of any type of procedure-related injury."[5]

- **Defensive medicine hasn't prevented mammography errors.** The *New York Times* reported in June 2002 some very disturbing facts about errors committed by radiologists in reading mammograms.[6] The theory of defensive medicine predicts that radiologists would err on the side of caution, and detect more false positives than false negatives. Unfortunately the opposite is true, with studies indicating that some doctors and clinics miss as many as one in three cancers. Despite the possibility of lawsuits, doctors with no aptitude for mammography continue to read mammograms. Clinics continue to employ doctors who read too few mammograms to keep their skills sharp. It appears that only reviews by regulators spur doctors and clinics to meet minimum standards.

- **Defensive medicine hasn't prevented hospital infections.** The *Chicago Tribune* reported on July 21, 2002 that some 75,000 Americans die each year because of infections acquired in hospitals that "were preventable, the result of unsanitary facilities, germ-laden instruments, unwashed hands and other lapses."[7] If medical providers fear being sued over the slightest lapse, why would doctors and nurses neglect to take the most elementary precautions of washing their hands and changing scrub uniforms? Why would American hospitals "have collectively pared cleaning staffs by 25 percent since 1995"?[8] Previously, consultants retained by medical provider groups have argued that medical providers *overspend* on precautionary measures by five to nine percent.[9]

- **Defensive medicine hasn't caused hospitals to keep nursing staffs up-to-strength.** Two reports published in the past six months concluded that patients in hospitals where nurses had heavier workloads had a higher risk of dying.[10] One report found specifically that each additional patient per nurse corresponded to a seven percent increase in both patient mortality and deaths following complications.[11] Nevertheless, nursing shortages persist, even though the defensive medicine theory predicts over-staffing.

[1] CBO supra note 22.
[2] Chassin & Becher, "The Wrong Patient," 136 *Ann Intern Med.* 826 (2002).
[3] Agency for Health Care Administration, *Risk Management Reporting Summary*, March 2002.
[4] Barker et al, "Medication Errors Observed in 36 Heath Care Facilities," 162 Arch Intern Med. 1897 (2002).
[5] Bates et al, "The Costs of Adverse Drug Events in Hospitalized Patients," 277 JAMA 307 (1997).
[6] Moss, "Spotting Breast Cancer: Doctors Are Weak Link," New York Times, June 27, 2002.
[7] Berens, "Infection epidemic carves deadly path," *Chicago Tribune*, July 21, 2002. This number is attributed to the "Tribune's analysis, which adopted methods commonly used by epidemiologists."
[8] Id.
[9] U.S. Department of Health and Human Services, *Confronting the New Health Care Crisis* (July 24, 2002)
[10] Needleman J., Buerhaus P., Mattke S., Stewart M., Zelevinsky K, *Nurse-Staffing Levels and the Quality of Care in Hospitals*, N Engl J Med (2002); 346:1715-1722, May 30, 2002. *See also:* Aiken LH, Clarke SP, Sloane DM, et al., *Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction,* JAMA, 2002;288:1987-1993, October 23/30, 2002.
[11] Aiken LH, Clarke SP, Sloane DM, et al., *Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction,* JAMA, 2002;288:1987-1993, October 23/30, 2002.

# Doctors' Aversion to Settlements May Increase Malpractice Insurance Costs

- **Medical malpractice insurers market their product based on aggressive defenses, not on low costs.** The Doctors Company, a leading doctor-owned insurer, states on its website: "When litigation is necessary, we dedicate more resources than our competitors to defend your good name. Our claims representatives and defense attorneys combine their knowledge of regional laws and jury experience to develop *aggressive, successful, defense strategies... We will not consent to settle without your written permission."* (emphasis theirs)[1] In other lines of insurance coverage, claims managers dispassionately evaluate the insured's exposure and make an objective decision as to whether to settle the claim. This rational calculation takes a back seat to pride and other emotional considerations when medical malpractice insurance is involved.

- **The result is that defense attorney fees are higher and verdicts are higher, pushing malpractice premiums higher.** According to A.M. Best figures cited on The Doctors Company website, the average doctor-owned medical malpractice insurer spends 32 percent of premiums on defense costs. The Doctors Company entices customers by boasting that 49 percent of its premiums are spent on defense costs.[2] A study by the West Virginia Insurance Commissioner found that one company spends 88 cents of each premium dollar on defense lawyers.

- **Malpractice insurance defense costs far exceed defense costs in other lines of insurance.** According to NAIC figures, defense costs incurred as a portion of direct premiums written amount to 4.8 percent for passenger auto liability, 7.1 percent for commercial auto liability, 16.5 for commercial general liability, and 28.9 percent for product liability.[3] Malpractice insurers seldom settle a case before the eve of trial, waiting until discovery is complete. They also take three times more cases to trial than other civil defendants. In 2000, the overall percentage of federal civil cases going to trial was 2.2, but 6.8 percent of medical malpractice cases went to trial.[4]

- **In reality, the liability insurance purchased by doctors is not just for risk management; it is also a public relations tool.** The Doctors Company and Medical Assurance both use the motto "Defending your reputation" in marketing themselves.[5] Kansas Medical Mutual Insurance Company (KaMMCO) cites "the existence of the National Practitioner Data Bank" as a reason that it is "more important than ever for health care professionals... to defend themselves against allegations of wrongdoing."[6] Doctors' complaints about high premiums must be viewed skeptically when much of the price quoted may pay for services entirely unrelated to managing risks of patient care. [7]

- **Evidence indicates that the negotiation process in medical malpractice cases fails, directly leading to the high verdicts that doctors complain about.** Pursuing a hardball defense strategy guided by emotion rather than reason will also affect the parties' ability to negotiate rational settlements. An Ohio State study compared medical and product liability negotiations. It found that product liability defense attorneys "correctly" predicted

jury outcomes (i.e. rejected plaintiff demands that were higher than the jury's eventual verdict) in 12 of the 14 cases studied. By contrast, defense attorneys made the correct settlement decision in only eight of 17 medical malpractice cases in the study. In one case, the defendant rejected a demand of $2 million only to be hit with a judgment for more than $8 million. The authors concluded that, "In malpractice cases, plaintiffs gained more than defendants from rejecting settlement offers and proceeding to trial. In product liability cases, defendants gained more than plaintiffs from eschewing settlement and defending claims in court… It appears that malpractice defendants—rather than plaintiffs—may be somewhat too inclined to resist settlement and push cases to trial."[8]

[1] http://www.thedoctors.com/resources/I-27/DocBrochure/Protectdoc4-5.html
[2] Id.
[3] National Association of Insurance Commissioners, *Statistical Compilation of Annual Statement Information for Property/Casualty Insurance Companies in 2000* (2001).
[4] Query to database of Federal District Court Civil Cases, maintained by Professors Theodore Eisenberg and Kevin Clermont of Cornell University. http://teddy.law.cornell.edu:8090/questata.htm
[5] See http://www.thedoctors.com/resources/I-27/DocBrochure/Protectdoc4-5.html, http://www.medicalassurance.com
[6] http://www.kammco-msc.com
[7] Other "extras" that may be included in the price of malpractice insurance include Defendant Reimbursement Coverage, that pays a doctor $500 per day to attend a trial, offered by ISMIE; and "defense coverage associated with the investigation of Medicare and Medicaid billing errors, regulatory agency actions, and… an initial consultation with an attorney to discuss potential countersuits," offered by KaMMCO.
[8] Merritt and Barry, "Is the Tort System in Crisis? New Empirical Evidence," 60 Ohio St. L. J. 315 (1999).

# Solutions to Reduce Medical Errors and Long-term Insurance Rates

### Implement Patient Safety Measures Proposed by the Institute of Medicine

Public Citizen believes in personal responsibility and accountability for negligence as one of the principal methods for deterring medical errors. Nevertheless, we acknowledge that the "systems approach" to patient safety advocated by the Institute of Medicine shows considerable promise. We are disappointed that some three years after the release of its report, almost nothing has been done to establish mandatory nationwide error reporting systems, identify unsafe practices, or raise performance standards.

- **Medication errors are among the most common preventable mistakes, but safety systems have been put in place in ver few hospitals.** Although experts using the systems approach have identified a number of promising strategies to reduce malpractice, few have been implemented. Experts have estimated that more than 950,000 serious drug errors occur annually in hospitals alone.[1] Recent studies show that computer physician order entry (CPOE) systems can reduce error rates by 55 percent,[2] CPOE is an electronic prescribing system that intercepts errors where they most commonly occur – at the time medications are ordered. Physicians enter orders into a computer, rather than on paper. Orders are automatically checked for potential problems, such as drug interactions or allergies. CPOE also resolves problems associated with deciphering doctors' notoriously bad handwriting. But in spite of these benefits, fewer than three percent of hospitals have fully implemented CPOE.[3]

- **Evidence-based hospital referral could save 4,000 lives every year, but has not been implemented.** Evidence-based hospital referral means directing patients with high-risk conditions to hospitals with characteristics shown to be associated with better outcomes. Dr. Adams Dudley, a researcher at the University of San Francisco at California, identified 10 surgical procedures for which outcomes were strongly related to hospital volume. Using data from California hospitals, he estimated that using evidence-based hospital referral for those 10 procedures would prevent over 4,000 deaths across the U.S. each year.[4]

- **Surgery performed on the wrong part of the body, to the wrong patient, and performing the wrong procedure on a patient are all completely preventable, yet continue to occur.** Such mistakes should *never* happen, according to a special alert reissued December 5, 2001 by the Joint Commission on Accreditation of Healthcare Organizations.[5] To prevent these accidents, the JCAHO recommends the surgical site be marked with a permanent marker. Sometimes referred to as "signing your site," doctors place their initials on the surgical site with a permanent marking pen in a way that cannot be overlooked and then actually operate through or next to the initials. JCAHO also recommends orally verifying the surgery in the operating room just before starting the operation.[6] Nevertheless, during 2001 in Florida hospitals alone there were 54 surgeries on the wrong part of the body, 16 wrong procedures performed and nine wrong patient surgeries.[7] Had Florida mandated the JCAHO recommendations in 2000, these 79 incidents would not have occurred.

### Open the National Practitioner Data Bank to Empower Consumers with Information About Their Doctors

Information about doctor discipline, including state sanctions, hospital disciplinary actions and medical malpractice awards is now contained in the National Practitioner Data Bank. HMOs, hospitals and medical boards can look at the National Practitioner Data Bank. Unfortunately, consumers cannot because the names of physicians in the database are kept secret from the public. Congress should lift the veil of secrecy and allow the people who have the most to lose from questionable doctors to get the information they need to protect themselves and their families.

### Limit Physicians' Workweek to Reduce Hazards Created by Fatigue

American medical residents work among the highest—if not the highest—number of hours in the professional world. They work up to 120 hours a week, including 36-hour shifts for several weeks at a time.[8] After 24 hours of wakefulness, cognitive function deteriorates to a level equivalent to having a 0. 10 percent blood alcohol level.[9] In other words, doctors who would be considered too unsafe to drive may still treat patients for 12 more hours. 41 percent of resident-physicians attribute their most serious mistake in the previous year to fatigue.[10] 45 percent of residents who sleep less than four hours per night report committing medical errors.[11] Working these extreme hours for years at a time also has ill-effects on doctors' own personal health and safety. Multiple studies in the medical literature demonstrate that sleep-deprived and overworked residents are at increased risk of being involved in motor vehicle collisions, suffering from depressed mood and depression, and giving birth to growth-retarded and/or premature infants.[12] If the maximum workweek for residents was limited to 80 hours it could considerably reduce mistakes due to fatigue and lack of supervision.

### Refine the Malpractice Insurance System

The number of classifications of doctor specialties for insurance rating purposes should be reduced to more broadly spread the risk. Risk pools for some are too small and thus overly influenced by a few losses and the concentration in a few specialties of doctors handling the highest risk patients. Often the high-risk patients are "referred up" from general practitioners who do not bear any of the risk.

### Improve Oversight of Physicians

Public Citizen has long sought greater consumer access to information about doctors, and there have been recent improvements in making that information available. Most state medical boards now provide some physician information on the Internet, but the information about disciplinary actions varies greatly, is often inadequate and can be difficult for people to access.[13]

For more than a decade, Public Citizen's Health Research Group has been carefully scrutinizing the performance of state medical boards. As reported in our *Questionable Doctors* publication,[14] too little discipline is being done. Too many state medical boards, despite their duty to protect the public, still believe their first responsibility is to rehabilitate "impaired physicians" and shield

them from the public's prying eyes. Fewer than one-half of one percent of the nation's doctors face any serious state sanctions each year. 2,708 total serious disciplinary actions a year, the number state medical boards took in 2001, are a pittance given estimates that between 44,000 and 98,000 deaths of hospitalized patients are caused by medical errors annually.

State discipline rates ranged from 10.52 serious actions per 1,000 doctors (Arizona) to 0.73 actions per 1,000 physicians (District of Columbia), a 14.4-fold difference between the best and worst states. If all the boards did as good a job as the lowest of the top five boards, Kentucky's rate of 6.32 serious disciplinary actions per 1,000 physicians, it would amount to a total of 5,089 serious actions a year. That would be 2,381 more serious actions than the 2,708 that actually occurred in 2001. It is likely that patients are being injured or killed more often in states with poor doctor disciplinary records than in states with consistent top performances.

Negligent doctors are rarely disciplined with loss or suspension of their license for inferior care. Instead, state medical boards focus on more easily documentable offenses such as prescription drug violations and fraud convictions or disciplinary action in another state as potential indicators of substandard care. Congress could encourage better oversight through grants to state medical boards, tied to the boards' agreements to meet performance standards. The following state reforms would help protect patients:

- **Reform medical board governance.** States should sever any remaining formal, debilitating links between state licensing boards and state medical societies. Members of medical boards (and separate disciplinary boards, where present) should be appointed by the governor, and the governor's choice of appointees should not be limited to a medical society's nominees. At least 50 percent of the members of each state medical board and disciplinary board should be well-informed and well-trained public members who have no ties to health care providers and who, preferably, have a history of advocacy on behalf of patients. The governor should appoint members to the Medical Board whose top priority is protecting the public's health, not providing assistance to physicians who are trying to evade disciplinary actions.

- **Beef up medical board funding and staffing.** State legislatures should permit medical boards to spend all the revenue from medical licensing fees, rather than being forced to give part to the state treasury. The medical boards should raise their fees to $500 a year. All boards could benefit from hiring new investigators and legal staff. Boards should employ adequate staff to process and investigate all complaints within 30 days, to review all malpractice claims filed with the board, to monitor and regularly visit doctors who have been disciplined to ensure their compliance with the sanctions imposed, and to ensure compliance with reporting requirements. They should hire investigators to seek out errant doctors, through review of pharmacy records, consultation with medical examiners, and targeted office audits of those doctors practicing alone and suspected of poor care.

- **Require risk prevention.** States should adopt a law, similar to one in Massachusetts, that requires all hospitals and other health care providers to have a meaningful, functioning risk prevention program designed to prevent injury to patients. Massachusetts also requires all adverse incidents occurring in hospitals or in doctors' offices to be reported to the medical board.

- **Require periodic recertification of doctors based on a written exam and audit of their patients' medical care records.**

[1] Birkmeyer JD, Birkmeyer CM, Wennberg, DE Young MP, *Leapfrog Safety Standards: potential benefits of universal adoption*. The Leapfrog Group. Washington, DC: 2000. Available at: http://www.leapfroggroup.org/PressEvent/Birkmeyer_ExecSum.PDF.
[2] Bates DW, Leape LL, Cullen DJ, Laird N, et al. *Effect of computerized physician order entry and a team intervention on prevention of serious medical errors*. JAMA. 1998;280:1311-6.
[3] Sandra G. Boodman, "No End to Errors," *Washington Post*, December 3, 2002.
[4] Birkmeyer JD. *High-risk surgery—follow the crowd*. JAMA. 2000; 283:1191-3; See also Dudley RA, Johansen, KL, Brand R, Rennie DJ, Milstein A. *Selective Referral to High Volume Hospitals: Estimating Potentially Avoidable Deaths*. JAMA. 2000; 283: 1159-66.
[5] *A follow-up review of wrong site surgery*, JCAHO, Sentinel Event Alert, Issue 24, Dec. 5, 2001.
[6] *Joint Commission Issues Alert: Simple Steps By Patients, Health Care Practitioners Can Prevent Surgical Mistakes*. See JCAHO web site: http://www.jcaho.org/news+room/press+kits/joint+commission+issues+alert+simple+steps+by+patients,++health+care+practitioners+can+prevent+surg.htm
[7] Florida Agency for Health Care Administration, *Risk Management Reporting Summary, 24 Hour Reports and Code 15 Reports, 2001*, March 2002.
[8] American Medical Student Association, *Fact Sheet, Support H.R. 3236 limiting resident-physician work hours; See also:* http://www.amsa.org/hp/rwhfact.cfm.
[9] *Id.*
[10] *Id.*
[11] *Id.*
[12] Public Citizen, *Petition to the Occupational Safety and Health Administration requesting that limits be placed on hours worked by medical residents (HRG Publication #1570)*, April 30, 2001; See also: http://www.citizen.org/publications/release.cfm?ID=6771.
[13] See http://www.citizen.org/publications/release.cfm?ID=7168
[14] www.questionabledoctors.org

## Politicians Should Reject Proposals that Reduce Accountability for Negligence

There are three main critiques of the legal system that have been offered to justify changes to medical liability laws.

The first is that the system sometimes reaches erroneous results. Nobody would contend that any institution relying on fallible human beings is perfect. Fortunately, the legal system provides far more back-ups than other institutions in our society, through its transparency and its extensive appellate process. Judges can, and do, reverse decisions of juries when they act with passion or prejudice, as well as review decisions of lower courts. In recent years, the U.S. Supreme Court has expanded protections to defendants in civil cases much as it expanded protections to criminal defendants in the 1960s. We are confident that few, if any, unreasonable results survive the review process.

The second critique is that the transaction costs (court administrative and attorneys' fees) of the civil justice system are too high. We believe that the tort system is worth its transaction costs. Unlike a bare-bones no-fault system, the tort system marshals lawyers' investigations, experts' opinions, and jurors' determinations to answer complex safety questions and set minimum standards for consumer protection. Within the category of "transaction costs" are attorneys uncovering the Ford/Firestone scandal; Erin Brockovich's investigation of the poisonings in Hinkley, California; and the work that exposed tobacco company fraud in manufacturing and marketing cigarettes.

Nevertheless, both consumers and corporations agree that unnecessary transaction costs should be cut when possible. Defense lawyers have favored reduction of document discovery, and plaintiffs' lawyers have favored limits on the length of depositions. But care must be taken to ensure that the "cost-cutting" label is not used to disguise measures that advantage one side. Just as defendants are skeptical of reducing the size of juries from twelve to six, consumers and patients are skeptical of measures such as mandatory arbitration.

The third critique of the tort system is that it awards too much compensation. It is with this argument that we fully and vehemently disagree. As we have noted earlier, there is overwhelming evidence that most injuries are not being compensated.

The medical community needs to say explicitly why it thinks a 6-to-1 disparity in injuries to claims is not favorable enough. Do they think it should be a 12-to-1 disparity? 20-to-1? What is their justification? The Health Care Liability Alliance has on its website a comparison of American tort expenditures to those in Japan and Denmark. Are doctors suggesting that Americans should mimic the conflict-aversion of Japanese culture or the stoicism of Scandinavian culture? Is there something wrong with us Americans? Is our individualism excessive? Debate is being driven by anecdotes, slogans, and hyperbole, without an acknowledgment or discussion of the values underlying the system.

We deplore the efforts to place arbitrary caps on so-called "non-economic damages." This Orwellian term has been applied to damages for pain and suffering (for injuries resulting in paralysis, loss of limb, etc.), disfigurement, and loss of fertility in an effort to demean their importance. The tremendous amount of money spent on such things as pain relief medication, grief counseling, cosmetic surgery, and fertility treatments belies the absurd notion that such damages could be "non-economic." To make matters worse, caps by definition apply only to the most catastrophically injured victims.

Every reputable economist says that paid damages need to be equal to injury costs in order to force an industry to exercise safety precautions. The conservative appointees to the President's Council of Economic Advisors phrased it very well in their recent report on the tort system:

> [A] patient purchasing a medical procedure, for example, may be unlikely to fully understand the complex risks, costs and benefits of that procedure relative to others…In such a case, the ability of the individual to pursue a liability lawsuit in the event of an improper treatment, for example, provides an additional incentive for the physician to follow good medical practice. Indeed, from a broad social perspective, this may be the least costly way to proceed – less costly than trying to educate every consumer fully. In a textbook example, recognition of the expected costs from the liability system causes the provider to undertake the extra effort or care that matches the customer's desire to avoid the risk of harm. This process is what economists refer to as "internalizing externalities." In other words, the liability system makes persons who injure others aware of their actions, and provides incentives for them to act appropriately.[1]

Measures that reduce compensation will reduce patient safety. Reducing tort system expenditures does not reduce the cost of injuries but shifts them, and ultimately increases them. While it is unfortunate that doctors have had to cope with large spikes in liability premiums, the silver lining is the message that the tort system is sending about medical errors. Publicly, doctors are saying that the tort system is out of control and needs to be fixed. But privately, we are certain, doctors are saying that they need to get their house in order, and ramp up new patient safety systems and risk management efforts.

[1] Council of Economic Advisors, *Who Pays for Tort Liability Claims? An Economic Analysis of the U.S. Tort Liability System* (April 2002).

# Public Citizen Reports Analyzing the Medical Malpractice "Crisis" in Several States

**Executive Summaries of the Following States:**
**Arkansas**
**Florida**
**Mississippi**
**Nevada**
**New Jersey**
**Pennsylvania**
**Rhode Island**
**Texas**
**West Virginia**

***Full Reports available at*** www.citizen.org


**Congress Watch**
**Winter 2003**

# Medical Misdiagnosis in Arkansas: Challenging the Medical Malpractice Claims of the Doctors' Lobby

## Executive Summary from the Public Citizen's Congress Watch Report

***Full Report available at*** www.citizen.org

The Arkansas Medical Society and its allies have made a number of sensational allegations about what they call a malpractice "crisis." We agree that there is a *temporary* "crisis" and malpractice insurance costs have spiked over the last two years. But claims that it has been caused by "many frivolous lawsuits," an "out-of-control legal system," "an irrational lottery," or "astronomic jury verdicts" have no basis in fact.

This Public Citizen study, which examined statistics from numerous government agencies and other reputable sources, has two principal findings:

1) The medical malpractice "crisis" in Arkansas, as in the rest of the country, is not a long-term problem nor has it been caused by the legal system. It is a short-term problem triggered by a brief spike in medical malpractice insurance rates for some physicians. This spike in rates is a result of the cyclical economics of the insurance industry and investment losses caused by the country's economic slowdown.

2) A more significant, longer-term malpractice "crisis" faced by Arkansas is the unreliable quality of medical care being delivered – a problem that health care providers have not adequately addressed. Taking away people's legal rights, as is proposed under a cap on non-economic damages, would only decrease deterrence and reduce the quality of care.

Highlights of this report include:

- **The cost of medical negligence to Arkansas' patients and consumers is considerable, especially when measured against the cost of malpractice insurance to Arkansas' doctors.** Extrapolating from Institute of Medicine findings, we estimate that medical errors cause 418 to 931 preventable deaths in Arkansas each year. The cost resulting from preventable medical errors to Arkansas' residents, families, and communities is estimated at $161 million to $275 million each year. But the cost of medical malpractice insurance to Arkansas' doctors is less than $40 million a year.

- **Arkansas doctor's liability premiums are among the lowest in the nation.** Malpractice insurance premiums in Arkansas are some of the lowest in all 50 states and the District of Columbia, according to data collected by *Medical Liability Monitor*. The median premium for a general surgeon practicing in Arkansas in 2002 was $16,400 – about the same amount paid by general surgeons in North Dakota or South Dakota, and higher than those in only four other states.

- **Government data shows that large malpractice award payments have been the rare exception in Arkansas.** According to the federal government's National Practitioner Data Bank (NPDB), Arkansas physicians made only two multi-million dollar award payments between 1998 and 2001. The largest was only $2,550,000. The number of large (more than $100,000) malpractice payments in Arkansas remained constant over the past four years, and so has the total amount of malpractice payments – declining from $15.8 million in 1998 to $15.1 million in 2001. Adjusting for inflation, this steady level of awards represents a significant decline in dollar value.

- **Government data show that malpractice payments in Arkansas have increased at a slower pace than national medical costs.** According to the National Practitioner Data Bank, the median medical malpractice payment by an Arkansas physician to a patient rose 48.6 percent between 1992 and 2002, or less than 5 percent a year. However, during those same years, medical costs increased by 53.7 percent nationally, or 5.4 percent a year. (Medical costs typically represent the lion's share of most malpractice awards.) Moreover, between 1999 and 2002, the median malpractice payment by an Arkansas physician actually dropped by more than 10 percent.

- **Arkansas' cumulative median malpractice payment has remained less than the national average.** Among the 50 states and the District of Columbia, Arkansas historically has ranked below the national average for the median malpractice payment by a physician to a patient. According to the NPDB, the cumulative median malpractice payment from 1991 to 2001 was $90,000 in Arkansas – compared with $100,000 nationally for the same period.

- **The number of Arkansas malpractice lawsuits filed in 2002 was less than in the preceding years.** In each of the past two years, which was the height of the insurance "crisis," the number of malpractice lawsuits filed in the state decreased. In 2002, 371 malpractice cases were filed in Arkansas, compared with 383 in 2001, and 413 in 2000. Overall, this represented a 10 percent decrease in lawsuits filed.

- **Doctors diagnose a crisis where the Chamber of Commerce sees none.** The American Medical Association added to a false sense of crisis when it included Arkansas on a list of states showing "problem signs" with their medical liability systems. On the same list, however, the AMA included Delaware and Virginia – states that the U.S. Chamber of Commerce ranks first and second among states with the *best* liability systems.

- **The number of doctors in Arkansas has been increasing.** Despite gloomy forecasts issued by those declaring a malpractice "crisis" in the state, the Arkansas State Medical Board reports that from 1998 to 2002 the state experienced an increase of 209 doctors, an average of 52 additional doctors each year. In 1995, Arkansas had 192 doctors for each 100,000 citizens. By 2001, the ratio was 212 per 100,000, an improvement of 10.4 percent.

- **"Repeat offender" physicians are responsible for the bulk of malpractice costs.** According to the federal government's National Practitioner Data Bank, which covers malpractice judgments and settlements since September 1990, 2.6 percent of Arkansas' doctors have made two or more malpractice payments to patients. These repeat

offender doctors are responsible for 43.7 percent of all payments. Overall, they have paid out $48.9 million in damages. Even more surprising, less than 1 percent of Arkansas' doctors, each of whom has paid three or more malpractice claims, are responsible for 20.3 percent of all payments.

- **Repeat offender doctors suffer few consequences in Arkansas.** The Arkansas state government and the state's health-care providers have done little to rein in those doctors who repeatedly commit negligence. According to the National Practitioner Data Bank and Public Citizen's analysis of NPDB data, disciplinary actions have been few and far between for Arkansas physicians. Of the 153 physicians in Arkansas who have made two or more payments to patients for malpractice since 1990, only 15 have been disciplined by the Arkansas State Board of Medicine – that is fewer than one out of 10. Moreover, only 14 percent of those doctors who made three or more malpractice payments were disciplined by the Board. A brief description of eight repeat offender doctors is contained in the body of this report.

- **Where's the doctor watchdog?** The Arkansas State Board of Medicine is dangerously lenient with doctors, repeatedly letting serious and sometimes repeat offenders off the hook. In 2001, only 24 doctors in Arkansas had serious sanctions levied against them. Arkansas took 4.18 serious actions per 1,000 doctors – slightly better than the national average, but only half as good as the best performing states and not nearly high enough to prevent bad doctors from practicing. Further, Arkansas is one of 10 states that provides no public information about doctors disciplined by their licensing boards.

- **The spike in medical liability premiums was caused by the insurance cycle, not by "skyrocketing" malpractice awards.** J. Robert Hunter, one of the country's most knowledgeable insurance actuaries and director of insurance for the Consumer Federation of America, recently analyzed the growth in medical liability premiums. He found that amounts charged for premiums do not track losses paid, but instead rise and fall in concert with the state of the economy. When the economy booms and investment returns are high, companies maintain premiums at modest levels; however, when the economy falters and interest rates fall, companies increase premiums.

- **Insurer mismanagement compounded the problems.** Underpriced premiums, reckless cash-flow policies, and ill-fated involvement with Enron and asbestos subsidiaries forced one major carrier, the St. Paul Companies, to stop offering malpractice insurance. The company had covered more than 40 percent of Arkansas' doctors. According to a *Wall Street Journal* analysis, St. Paul generated large cash reserves by raising rates during the 1980s, and then released $1.1 billion from reserves between 1992 and 1997 – dramatically boosting its bottom line. This artificial profitability attracted numerous, smaller competitors into the malpractice insurance market and led to widespread price-cutting. By the end of the 1990s, revenue from premiums no longer could cover malpractice claims, causing some companies to collapse and others, like St. Paul, to drop coverage.

# Florida's Real Medical Malpractice Problem: Bad Doctors and Insurance Companies Not the Legal System

## Executive Summary from the Public Citizen's Congress Watch Report

***Full Report available at*** www.citizen.org

The American Medical Association, the Florida Medical Association and their allies in the business community have made a number of sensational allegations about what they call a "malpractice crisis." Their allegations about the current state of medical malpractice litigation include: "many frivolous lawsuits," "out-of-control legal system," "explosions in costs," "astronomic jury verdicts," "an irrational lottery," to cite a few.

This new Public Citizen study challenges these assertions by examining statistics from two sources that have not yet been considered in the debate about medical liability – injury data reported by hospitals to Florida's Agency for Health Care Administration and the "public use" file of the National Practitioner Data Bank, which reports on doctors who commit malpractice.

According to the Institute of Medicine (IOM), which completed a comprehensive report on the medical malpractice issue in 1999, medical errors "are a leading cause of death in the United States… At least 44,000 and perhaps as many as 98,000 Americans die in hospitals each year as a result of medical errors. Deaths due to preventable adverse events exceed the deaths attributable to motor vehicle accidents (43,458), breast cancer (42,297) or AIDS (16,516). Costs attributable to medical errors are estimated at between $17 billion and $29 billion, according to the IOM. Given these shocking numbers, it can be no surprise that medical liability premiums are too high for some specialties.

But the spike in some medical malpractice premiums is an insurance industry pricing and profitability problem – not a legal system problem. As this study shows, the assertions made about the medical liability system in Florida are, at best, highly exaggerated, and, at worst, totally false.

Rather than reducing the real threats that medical care poses to their patients, the doctor's lobby has proposed to shift the costs of injuries onto individuals, their families, voluntary organizations and taxpayers. This is unfortunate because doctors and patients and consumers should be allies on this issue – not be pitted against each other. Doctors should join together with patients and consumers and work hard to reform the poor business practices of the insurance industry, rather than blame the victims and their lawyers, and to better police the very small number of their profession who commit most of the state's malpractice.

The following are the major findings of this report:

- **The number of medical errors reported by Florida hospitals exceeds the number of medical malpractice *claims* filed each year by 6 to 1.** About two-thirds of malpractice claims arise during hospitalization. Reports prepared by Florida's Agency for Health Care Administration have compared reports of adverse incidents in hospitals to the filing of new malpractice claims. From 1996 through 1999, Florida hospitals reported 19,885 incidents but only 3,177 medical malpractice claims. This means that for every 6 adverse incidents in the hospital only 1 malpractice claim is ever filed. The agency's 2001 report contains these astonishing figures on medical errors in Florida hospitals: 9 incidents of surgery performed on the wrong patient; 16 incidents where the wrong procedure was performed; 54 incidents where the procedure was performed on the wrong site; and 122 incidents where a foreign object was left in a patient after surgery. See Section I.

- **Six percent of the doctors in Florida are responsible for half the malpractice.** Public Citizen's analysis of the federal government's National Practitioner Data Bank information, which records malpractice judgments and settlements since September 1990, found that 2,674 of the state's 44,747 doctors have paid two or more malpractice awards to patients. These doctors are responsible for 51 percent of all payments. Overall, these doctors have paid $1.2 billion in damages. Despite the fact that claims history predicts future claims, neither the state medical licensing boards nor the insurance market have been effective in reducing malpractice. See Section II, which includes examples of the most egregious repeat offenders.

- **Many of Florida's most dangerous doctors continue to practice and the state watchdog is asleep on the job.** There are 1,555 physicians who have been disciplined by Florida's state medical and osteopathic boards for incompetence, misprescribing drugs, sexual misconduct, criminal convictions, ethical lapses and other offenses. Many were not required to stop practicing, even temporarily. In fact, only 36 percent of Florida's disciplinary actions in 2001 were serious – meaning license revocation, suspension, surrender or probation. When compared to the rest of the country, only two states were worse in that regard, Wisconsin (22 percent) and North Carolina (32 percent). Overall, Public Citizen ranks Florida 26$^{th}$ among the states in terms of the performance of its state medical board, which is charged with policing the medical profession. See Section III.

- **Rate increases are up for many other types of insurance in Florida.** Doctors like to blame lawyers and the legal system for rising malpractice insurance rates. But these rate increases are largely the result of the economics of the insurance industry – major stock market losses mean insurers cannot continue to offer artificially low rates in the hope of attracting more customers. The resulting cycle of insurance rate hikes is today propelling the costs of all insurance products upward. Types of insurance and rate increases in Florida during 2002 include: medical malpractice (26 percent), health insurance (20 to 28 percent); auto (10.6 percent); and homeowners (15.7 percent). See Section IV.

# Medical Misdiagnosis in New Jersey: Challenging the Medical Malpractice Claims of the Doctors' Lobby

## Executive Summary from the Public Citizen's Congress Watch Report

***Full Report available at*** www.citizen.org

The Medical Society of New Jersey and its political allies have made a number of sensational allegations about what they call a malpractice "crisis." We agree that there is a *temporary* "crisis" and malpractice insurance costs have spiked over the last two years. But claims that it has been caused by "frivolous malpractice claims," "unbridled lawsuits," or a legal system that is "running amok" have no basis in fact.

This Public Citizen study, which examined statistics from numerous government agencies and other reputable sources, has two principal findings:

1) The medical malpractice "crisis" in New Jersey, as in the rest of the country, is not a long-term problem nor has it been caused by the legal system. It is a short-term problem triggered by a brief spike in medical malpractice insurance rates for some physicians. This spike in rates is a result of the cyclical economics of the insurance industry and investment losses caused by the country's economic slowdown.

2) A more significant, longer-term malpractice "crisis" faced by New Jersey residents is the unreliable quality of medical care being delivered – a problem that health care providers have not adequately addressed. Taking away people's legal rights, as is proposed under a cap on non-economic damages, would only decrease deterrence and reduce the quality of care.

Highlights of this report include:

- **The cost of medical negligence to New Jersey's patients and consumers is considerable, especially when measured against the cost of malpractice insurance to New Jersey's doctors.** Extrapolating from Institute of Medicine (IOM) findings, we estimate that medical errors cause 1,316 to 2,930 preventable deaths in New Jersey each year. The cost resulting from preventable medical errors to New Jersey's residents, families and communities is estimated at $508 million to $867 million each year. But the cost of medical malpractice insurance to New Jersey's doctors is less than $290 million a year.

- **The annual amount of medical malpractice insurance premiums paid in New Jersey has barely increased since 1992.** The amount New Jersey health-care providers paid in premiums for malpractice insurance in 2001 was $290 million – compared with $256 million in 1992. This is an overall increase of only 13 percent, or 1.4 percent a year. During that same time period, health care costs increased by 46.7 percent nationwide or 5.2 percent a year. Adjusting for inflation and a growing number of doctors in the state, this increase in malpractice premiums represents a significant decline in dollar values.

- **Annual malpractice payments to patients by New Jersey insurers have barely increased since 1992.** The amount of malpractice payments made by insurers to New Jersey patients in 2001 was $235 million – compared with $231 million in 1992. This is an overall increase of only 2 percent, far below the medical inflation index over that period of time.

- **There has been no "explosion" in malpractice litigation in New Jersey.** Physicians and their lobbyists justify efforts to restrict patients' legal rights by describing "unbridled lawsuits," and a legal system that is "running amok" – but official state statistics show that the number of malpractice lawsuits filed over the past two years has dropped significantly from previous years. Malpractice cases filed in 1998 numbered 1,776 but declined to 1,656 in 2002 – a drop of 7 percent.

- **"Repeat offender" doctors are responsible for the bulk of malpractice payments.** According to the federal government's National Practitioner Data Bank (NPDB), which covers malpractice judgments and settlements since September 1990, 5.5 percent of New Jersey's doctors have made two or more malpractice payments to patients. These repeat offender doctors are responsible for 61.1 percent of all payments. Overall, they have paid out $939.4 million. Even more surprising, 2.1 percent of New Jersey's doctors (636), each of whom has paid three or more malpractice claims, are responsible for 36.9 percent of all payments.

- **Repeat offender doctors suffer few consequences in New Jersey.** The New Jersey state government and the state's health care providers have done little to rein in those doctors who repeatedly commit negligence. According to the National Practitioner Data Bank and Public Citizen's analysis of NPDB data, disciplinary actions have been few and far between for New Jersey physicians. Only 10.8 percent of those doctors who made four or more malpractice payments have been disciplined by the New Jersey Board of Medical Examiners. And only 20 percent of those doctors who made five or more malpractice payments have been disciplined.

- **Where's the doctor watchdog?** In 2001, only 105 doctors in New Jersey had serious sanctions levied against them by the state's Board of Medical Examiners for incompetence, misconduct, ethical lapses or other offenses. Most of these doctors were not required to stop practicing even temporarily. New Jersey ranks 23rd among the states when its diligence in taking disciplinary actions is measured. But it is important to emphasize that New Jersey has a great deal of room for improvement – it disciplines doctors at only one-third the rate of the top state (Arizona).

- **The spike in medical liability premiums was caused by the insurance cycle, not by "skyrocketing" malpractice awards.** J. Robert Hunter, one of the country's most knowledgeable insurance actuaries and director of insurance for the Consumer Federation of America, recently analyzed the growth in medical liability premiums. He found that amounts charged for premiums do not track losses paid, but instead rise and fall in concert with the state of the economy. When the economy booms and investment returns are high, companies maintain premiums at modest levels; however, when the economy falters and interest rates fall, companies increase premiums.

- **Poor business strategies by a leading insurance company compounded New Jersey's problems.** Pressure on physician premiums intensified after May 2002, when one of New Jersey's biggest carriers, Medical Inter-Insurance Exchange (MIIX), announced it would stop renewing policies. The company had covered 37 percent of all the doctors in New Jersey. The state's Department of Banking and Insurance attributed the company's problems to its ill-fated decisions to expand into other states and to increase its stock market investments.

- **Malpractice insurance has remained affordable for the vast majority of New Jersey physicians.** The Commissioner of Banking and Insurance has reported to the Legislature that "relatively few" – approximately 7.4 percent – of the state's doctors have experienced large premium increases, even in high-risk specialties.

- **No exodus of physicians from New Jersey is evident.** Despite gloomy rhetorical descriptions of "doctors leaving the profession in droves," there is no shortage of doctors in New Jersey. Statistics from American Medical Association show that New Jersey ranks 8th best among all 50 states and the District of Columbia for its ratio of doctors to residents – and this ratio has improved significantly in recent years. In 1990, New Jersey had 267 doctors per 100,000 residents. By 2001, that ratio had climbed to 328 doctors per 100,000 residents. This places the state well ahead of the national average, which in 2001 was 286 doctors per 100,000 residents.

- **Rather than facing "runaway litigation," doctors benefit from a claims gap.** A landmark Harvard Medical Practice Study and other studies have found that only a small percentage of medical errors result in lawsuits. Twelve years ago, Harvard researchers found that only one in eight preventable medical errors committed in hospitals results in a malpractice claim. Researchers replicating this study made similar findings in Utah and Colorado. From 1996 through 1999, Florida hospitals reported 19,885 incidents but only 3,177 medical malpractice claims. In other words, for every six medical errors only one claim is filed.

- **Malpractice insurance costs amount to only 3.2 percent of the average physician's revenues.** According to experts at the Medicare Payment Advisory Commission (MedPAC), liability insurance premiums make up just a tiny part of a physician's expenses and have increased by only 4.4 percent over the past year. The increase in this expense is noticeable primarily because of the decreases in reimbursements that doctors are receiving from HMOs and government health programs.

- **Plaintiffs drop 10 times more claims than they pursue**. Based on Physician Insurer Association of America (PIAA) figures, Public Citizen estimates that about 54 percent of claims are being abandoned by patients. Attorneys often may send a statutorily required notice of intent to claim or file a lawsuit in order to meet the requirements of the statute of limitations but, after collecting medical records and consulting with experts, decide not to pursue the claim. We estimate that the number of cases withdrawn voluntarily by plaintiffs was 92,621, *10 times* the number of cases that were taken to trial and lost during that period (9,293). The percentage of claims pursued by plaintiffs to final rejection by a jury is only *five percent.*

- **The small number of claims pursued to a defense verdict are not frivolous.** Researchers at the American Society of Anesthesiologists arranged for pairs of doctors to review 103 randomly selected medical negligence claims files. The doctors were asked to judge whether the anesthesiologist in question had acted reasonably and prudently. The doctors only agreed on the appropriateness of care in 62 percent of the cases; they disagreed in 38 percent of cases. The researchers concluded, "These observations indicate that neutral experts (the reviews were conducted in a situation that did not involve advocacy or financial compensation) commonly disagree in their assessments when using the accepted standard of reasonable and prudent care."

- **So-called "non-economic" damages are real and not awarded randomly.** "Non-economic" damages aren't as easy to quantify as lost wages or medical bills, but they compensate the pain and suffering that accompany any loss of normal functions (e.g. blindness, paralysis, sexual dysfunction, lost bowel and bladder control) and inability to engage in daily activities or to pursue hobbies, such as hunting and fishing. This category also encompasses damages for disfigurement and loss of fertility. According to PIAA, the average payment between 1985 and 2001 for a "grave injury," which encompasses paralysis, was only $454,454.

- **No evidence supports the claim that jury verdicts are random "jackpots."** Studies conducted in California, Florida, North Carolina, New York and Ohio have found that jury verdicts bear a reasonable relationship to the severity of the harm suffered. In total the studies examined more than 3,500 medical malpractice jury verdicts and found a consistent relationship between the severity of the injury and the size of the verdict. Uniformly the authors concluded that their findings did not support the contention that jury verdicts are frequently unpredictable and irrational.

- **Empirical evidence does not confirm the existence of "defensive medicine" – and patient injuries refute it.** The Congressional Budget Office was asked to quantify the savings from reduced "defensive medicine" if Congress passed H.R. 4600. This bill, which passed the House in 2002, contained very stringent restrictions on a patient's ability to recover damages. CBO declined, saying that any such "estimates are speculative in nature, relying, for the most part, on surveys of physicians' responses to hypothetical clinical situations, and clinical studies of the effectiveness of certain intensive treatments. Compounding the uncertainty about the magnitude of spending for defensive medicine, there is little empirical evidence on the effect of medical malpractice tort controls on spending for defensive medicine and, more generally, on overall health-care spending. Using broader measures of spending, CBO's initial analysis could find no statistically significant connection between malpractice tort limits and overall health care spending." In addition, numerous studies continue to document preventable medical errors ranging from invasive procedures performed on the wrong patients, medication errors, misreading of test results and unsanitary conditions – all mistakes that any widespread practice of "defensive" medicine could have been expected to reduce.

# Medical Misdiagnosis in Pennsylvania: Challenging the Medical Malpractice Claims of the Doctors' Lobby

## Executive Summary from the Public Citizen's Congress Watch Report

***Full Report available at*** www.citizen.org

The Pennsylvania Medical Society (PMS) and its medical industry allies have made a number of sensational allegations about what they call a malpractice "crisis." We agree that there is a *temporary* "crisis" in that malpractice insurance costs have spiked over the last two years. But the PMS's allegations that it is caused by "many frivolous lawsuits," an "out-of-control legal system," "an irrational lottery" and "astronomic jury verdicts" has no factual basis.

This Public Citizen study, which examined statistics from numerous government agencies and other reputable sources, has two principal findings:

1) The medical malpractice "crisis" in Pennsylvania, as in the rest of the country, is not a long-term problem nor is it caused by the legal system. It is a short-term problem caused by a brief spike in medical malpractice insurance rates for some physicians. This spike in rates is a result of the cyclical economics of the insurance industry and declining investments caused by the country's economic slowdown.

2) The more significant longer-term malpractice "crisis" faced by Pennsylvanians is the quality of medical care being delivered, which health care providers have not adequately addressed. Taking away people's legal rights, such as is proposed with a cap on non-economic damages, would only decrease deterrence and reduce the quality of care.

Highlights of the report include:

- **The costs of medical negligence to Pennsylvania's patients and consumers is considerable, especially when compared to the cost of malpractice insurance to Pennsylvania's doctors.** Extrapolating from Institute of Medicine findings, we estimate that there are 1,920 to 4,277 preventable deaths in Pennsylvania each year that are due to medical errors. The costs resulting from preventable medical errors to Pennsylvania's residents, families and communities is estimated at $742 million to $1.3 billion each year. But the cost of medical malpractice insurance to Pennsylvania's doctors is less than $731 million a year.

- **Government data show that medical malpractice awards have increased at a much slower pace in Pennsylvania than claimed by the Pennsylvania Medical Society.** According to the federal government's National Practitioner Data Bank (NPDB), the median medical malpractice payment by a Pennsylvania physician to a patient rose 33 percent from 1997 to 2001, from $150,000 to $200,000, or eight percent a year. By contrast, medical organizations in Pennsylvania quote data from Jury Verdict Research (JVR), a private research firm, indicating that verdicts rose almost 43 percent from 1997 to 2000, from $700,000 to $1 million, or 14 percent a year. The reason for the difference: JVR collects only

jury *verdict* information that is reported to it by attorneys, court clerks and stringers. The NPDB is the most comprehensive source of information that exists because it includes both verdicts *and* settlements. Ninety-six percent of all medical malpractice cases are settled, as opposed to decided by a jury, and settlements result in much lower awards than jury verdicts.

- **Government data show that medical malpractice awards in Pennsylvania have increased at a slower pace than national health insurance premiums.** While NPDB data show that the median medical malpractice payment in Pennsylvania rose 33 percent from 1997 to 2001 (an average of 8.3 percent a year). The national average premium for single health insurance coverage increased 39 percent over that time period (9.5 percent a year). Payments for health care costs, which directly affect health insurance premiums, make up the lion's share of most medical malpractice awards.

- **Government data reveals little growth in medical malpractice claims paid in Pennsylvania.** According to the NPDB, there has been only a modest increase in the total number of malpractice claims paid in Pennsylvania from 1995 through 2001. The difference between the 957 claims paid in 1995 and the 1,049 claims reported in 2001 is less than ten percent over six years, or 1.6 percent a year.

- **Large verdicts in Pennsylvania have dramatically declined.** The number of large jury verdicts in Pennsylvania and the amount paid in medical malpractice in these large verdicts decreased dramatically in recent years. From 2000 to 2002, the number of jury awards of $1 million or more dropped by 50 percent (from 44 to 22) while the overall amount of these awards decreased by over 75 percent (from $415 million to $93 million).

- **At the height of the medical malpractice "crisis," the number of licensed physicians in Pennsylvania actually *increased* by 7.5 percent.** According to data provided by the Pennsylvania State Medical Board, the government agency charged with issuing medical licenses to qualified doctors, 34,330 physicians were licensed and practicing medicine in Pennsylvania during 2001. In 2002, the Board issued 36,921 licenses—a 7.5 percent increase over 2001. This increase in physician population is not isolated. Over the past seven years, the number of doctors licensed and residing in Pennsylvania increased by 14 percent. The theory that skyrocketing medical malpractice insurance premiums are forcing doctors to flee the state is not borne out by the facts.

- **Pennsylvania ranks 5th in doctor population.** According to the American Medical Association (AMA), Pennsylvania is home to five percent of the nation's doctors, a distinction that ranked the state's physician population the 5th highest in the nation. Further, the AMA reports that Pennsylvania has one of the largest physician populations under the age of 35, with 5.5 percent of the nation's younger doctors practicing in Pennsylvania.

- **Repeat offender physicians are responsible for the bulk of medical malpractice costs.** According to the federal government's National Practitioner Data Bank, which covers malpractice judgments and settlements since September 1990, 10.6 percent of the state's doctors, have paid two or more malpractice awards to patients. These repeat offender doctors are responsible for 84 percent of all payments. Even more surprising, only 4.7 percent of Pennsylvania's doctors (1,838), each of whom has paid three or more malpractice claims, are responsible for 51.4 percent of all payments. This ranks Pennsylvania

worst among all fifty states in terms of the number of repeat offender doctors (three or more malpractice payments) as a percent of all doctors.

- **Repeat offender doctors suffer few consequences in Pennsylvania.** Public Citizen's analysis of the federal government's NPDB found that only 5.1 percent of those doctors who made five or more malpractice payments were disciplined by Pennsylvania's State Board of Medicine. Only 6.8 percent of those doctors who made 10 or more malpractice payments were disciplined.

- **Where's the doctor watchdog?** Pennsylvania's State Board of Medicine is dangerously lenient with doctors, regularly letting serious and sometimes repeat offenders off the hook. In Public Citizen's ranking of state medical boards, Pennsylvania ranked 36th out of 50 states and the District of Columbia. The ranking is based on the number of serious disciplinary actions per 1,000 doctors in each state. In 2001, nationally there were 3.36 serious actions taken for every 1,000 physicians. Pennsylvania is among the bottom third of U.S. states when its diligence in taking disciplinary actions is measured – 2.18 serious actions per 1,000 doctors.

- **The spike in medical liability premiums was caused by the insurance cycle, not by "skyrocketing" malpractice awards.** J. Robert Hunter, one of the country's most knowledgeable insurance actuaries and director of insurance for the Consumer Federation of America, recently analyzed the growth in medical liability premiums. He found that amounts charged for premiums do not track losses paid, but instead rise and fall in concert with the state of the economy. When the economy booms and investment returns are high, companies maintain premiums at modest levels; however, when the economy falters and interest rates fall, companies increase premiums.

- **Insurer mismanagement compounded the problems.** Artificially low premiums in the 1990s, market competition, and accounting irregularities forced the Phico and St. Paul insurance companies to stop offering medical malpractice insurance in Pennsylvania. Phico Insurance Co. was the third-largest malpractice insurer in the state, and the St. Paul Companies, Inc. was the seventh largest. Together they carried about 18 percent of the state's physicians. In each case, the departure of the insurance company from the market had little to do with malpractice award payments than with the mismanagement of the company itself. Phico had been placed under the supervision of insurance regulators and was later sued by the state's Insurance Department. The lawsuit alleged that Phico directors ignored signs of financial trouble at the company and pressured the board to pay dividends at a time when the insurer's surplus "was declining drastically and significant strengthening of loss reserves was required." As the *Wall Street Journal* found in a front page investigative story on June 24, 2002, when malpractice claims increased in the 1980s, St. Paul and its competitors sharply raised rates. But, as the frequency and size of claims leveled off, St. Paul realized it had set too much money aside for malpractice payments. The company then released $1.1 billion from its reserves between 1992 and 1997, which dramatically boosted its bottom line. St. Paul's apparent profitability attracted numerous, smaller carriers into the malpractice insurance market, which led to widespread, competitive price-cutting. By the end of the 1990s, the revenue from premiums decreased to the point that insurers no longer could cover malpractice claims. Some collapsed and others, like St. Paul, withdrew from the market.

# Medical Misdiagnosis in Rhode Island: Challenging the Medical Malpractice Claims of the Doctors' Lobby

## Executive Summary from the Public Citizen's Congress Watch Report

***Full Report available at www.citizen.org***

The Rhode Island Medical Society and its political allies have made dire predictions about an impending malpractice "crisis" in their state. These worries are based on the experiences of other states, where some doctors have faced significantly increased malpractice insurance premiums over the past two years. Rhode Island's medical establishment may be reacting to the potential for a *temporary* "crisis" – but its arguments that this is being triggered by "frivolous" malpractice claims or an explosion of "meritless" lawsuits have no basis in fact.

This Public Citizen study, which examines statistics from numerous government agencies and other reputable sources, has two principal findings:

1) The most significant, long-term malpractice "crisis" faced by Rhode Island residents is the unreliable quality of medical care being delivered by a relatively small proportion of doctors – a problem that health-care providers have not adequately addressed. Restricting access to legal remedies for patients who seek compensation for injuries, as is proposed under legislation introduced in Rhode Island, would only decrease deterrence and reduce the quality of care.

2) The medical malpractice premium "crisis" that Rhode Island doctors describe is not a long-term problem nor is it being caused by the legal system. It is a potential short-term problem triggered by a brief spike in medical malpractice insurance premiums for some physicians. This spike in rates is a result of the cyclical economics of the insurance industry and investment losses caused by the country's economic slowdown.

Highlights of this report include:

- **The cost of medical negligence to Rhode Island patients and consumers is considerable, especially when measured against the cost of malpractice insurance to Rhode Island doctors.** Extrapolating from Institute of Medicine (IOM) findings, we estimate there are 164 to 365 preventable deaths in Rhode Island each year that are due to medical errors. The costs resulting from preventable medical errors to Rhode Island residents, families and communities are estimated at $63 million to $108 million each year. But the cost of medical malpractice insurance to Rhode Island doctors is only $21.6 million a year.

- **There has been no sustained increase in the amounts of Rhode Island's annual malpractice payouts.** According to the National Practitioner Data Bank (NPDB), the total value of malpractice payouts made to patients in Rhode Island in 2001 was $22.8

million, up from $21.1 million in 1992. This increase of $1.7 million represents a change of only 8 percent over nine years, or 0.9 percent a year. During this same period, costs of medical care increased 47 percent nationwide, an average of 5.2 percent a year.

- **Official records show a significant decline in the number of malpractice payouts made in Rhode Island.** NPDB statistics contradict suggestions by Rhode Island doctors and their political allies that malpractice payouts have grown much more frequent. NPDB data show that the number of payouts actually declined 21 percent from 1997 to 2001 (the most recent five years for which complete statistics are available).

- **As a group, Rhode Island doctors have seen only modest increases in their liability insurance premiums.** According to data from the National Association of Insurance Commissioners (NAIC), the total amount that Rhode Island doctors paid in malpractice insurance premiums in 2001 was $21.6 million, compared with $19.5 million in 1996. This is an increase of only 11 percent over five years. When adjusting for medical inflation and the growing number of physicians in the state, this represents a significant decline in actual dollars.

- **Malpractice insurance premiums are lower in Rhode Island than in neighboring states.** A comparison between medical malpractice premiums paid by Rhode Island doctors and premiums paid by doctors in neighboring New England states shows that Rhode Island doctors generally pay less – in some cases, much less. Rates for higher-risk specialists such as general surgeons and Ob/Gyns were anywhere from 1.5 percent to 40 percent less in Rhode Island than in Connecticut or Massachusetts.

- **Statistics contradict assertions that million-dollar malpractice payouts have become more frequent.** Proponents of legislation to impede the legal access of injured patients assert that "verdicts and settlements in medical malpractice actions exceeding $1 million have increased steadily over the past 20 years." In fact, numbers reported to the National Practitioner Data Bank (NPDB) show that Rhode Island has experienced no such recent pattern. From 1992 through 2001, the average number of malpractice payouts of a million dollars or more was less than two per year, and never exceeded three in any of those years. In 2001, the total number of payouts of $1 million or more was three. Additionally, the number of malpractice payouts between $500,001 and $1 million showed no steady, upward trend during these years, averaging just over eight per year. In 2001, the total number of payouts in this range was 11.

- **Malpractice payouts are insignificant when compared with the state's overall health-care expenditures.** Total spending on health care in Rhode Island was $4.5 billion in 1998. In that year, malpractice payouts made to patients in Rhode Island totaled $14.5 million – the equivalent of only 0.32 percent of health-care expenditures in the state.

- **There is no sign that doctors are abandoning Rhode Island.** In published comments, the president of the Rhode Island Medical Society described his state as "an increasingly hostile environment" and proclaimed: "The word is out that Rhode Island is not a great place to be a doctor." Statistics indicate, however, that Rhode Island's medical environment has attracted a steady increase in physicians. In 2002, there were 2,915

practicing physicians and osteopaths with Rhode Island addresses, compared with 2,623 in 1999, an increase of 11 percent.

- **Rhode Island's ratio of doctors-to-residents has increased.** According to the American Medical Association, Rhode Island had 277 non-federal doctors per 100,000 residents in 1990. By 2001, that ratio had increased to 365 doctors per 100,000 residents. This is the seventh highest ratio in the nation.

- **Repeat-offender doctors are responsible for half of medical malpractice.** According to the NPDB, which covers malpractice judgments and settlements since September 1990, 5 percent of Rhode Island's doctors have made two or more malpractice payouts to patients. These repeat-offender doctors are responsible for 53 percent of all payouts. Overall, they have paid out $104.7 million in damages. Even more disturbing, just 1.6 percent of Rhode Island's doctors, each of whom has paid three or more malpractice claims, are responsible for nearly 26 percent of all payouts.

- **Less than a third of doctors with four or more malpractice payouts have been disciplined.** According to the National Practitioner Data Bank and Public Citizen's analysis of NPDB data, 19 Rhode Island physicians have made four or more malpractice payouts, but only 31.6 percent of those doctors have been disciplined by the Rhode Island State Board of Medical Licensure and Discipline.

- **Five years after a disclosure law was adopted, consumers still can't get vital data.** Rhode Island has yet to fully implement a 1997 law that called for public disclosure of profiles containing information about individual physicians. Although some profiles are available online, they omit two crucial categories: malpractice information and criminal convictions. The system is scheduled for an update this summer, but the profiles still will not contain data on doctors' malpractice settlements.

- **The medical board is among the nation's least stringent when it comes to disciplining doctors.** Rhode Island ranks 42nd among all states and the District of Columbia when its diligence in taking disciplinary actions against doctors is measured. In 2001, the state Board of Medical Licensure and Discipline levied serious sanctions against only seven doctors for incompetence, misprescribing drugs, sexual misconduct, criminal convictions, ethical lapses or other offenses, according to an ongoing Public Citizen project that tracks "Questionable Doctors" nationwide. Nationally in 2001, there were 3.36 serious actions taken for every 1,000 physicians. The rate of serious actions by the Rhode Island Board of Medical Licensure and Discipline – 1.79 per 1,000 physicians – was roughly one-sixth of the rate in Arizona, which is the top-ranked state with 10.52 serious actions per 1,000 physicians.

- **Spike in medical liability premiums is caused by the insurance cycle, not by "skyrocketing" malpractice awards.** J. Robert Hunter, one of the country's most knowledgeable insurance actuaries and director of insurance for the Consumer Federation of America, recently analyzed the growth in medical liability premiums. He found that amounts charged for premiums do not track losses paid, but instead rise and fall in concert with the state of the economy. When the economy booms and investment returns are high, companies

maintain premiums at modest levels; however, when the economy falters and interest rates fall, companies increase premiums.

- **Rhode Island doctors have endured insurance cycles for 28 years.** As recently as February, the Rhode Island Medical Society's board of directors acknowledged that the state had witnessed up-and-down cycles in the medical liability insurance industry since the mid-1970s. In an advisory to members, the board recounted major problems that occurred with medical liability insurers in 1975, when coverage became largely unavailable; for a number of years beginning in 1987, when nine different "risk retention groups" began going bankrupt; and again in 1993, when a large, unrated carrier, Premier Alliance, became insolvent. The primary cause for these problems, the board concluded, has been "under-reserving" of funds by the insurance companies.

- **Insurance companies and their lobbyists admit caps on damages won't lower malpractice premiums.** Caps on "non-economic damages" are not part of Rhode Island's current legislative proposal, but they are included in a federal bill that the state's U.S. senators and congressmen will be considering. These caps, which limit compensation for pain and suffering, significantly reduce awards paid to catastrophically injured patients. But because such truly severe cases comprise a small percentage of medical malpractice claims, and because the portion that pays for defense lawyer fees dwarfs the portion of the insurance premiums that pay for compensation, caps do not lead to lower premiums. Insurance companies and their lobbyists understand this, and have said so on numerous public occasions.

- **So-called "non-economic" damages are real and not awarded randomly.** "Non-economic" damages aren't as easy to quantify as lost wages or medical bills, but they compensate the pain and suffering that accompany any loss of normal functions (e.g. blindness, paralysis, sexual dysfunction, lost bowel and bladder control) and inability to engage in daily activities or to pursue hobbies, such as hunting and fishing. This category also encompasses damages for disfigurement and loss of fertility. According to the PIAA, the average total payout between 1985 and 2001 for a "grave injury," which encompasses paralysis, was only $454,454.

- **Capping damages hurts women the most.** Limiting medical malpractice awards for non-economic injury has a disproportionate impact on women. The largest part of economic damages in many tort claims is lost wages, and women earn on average less money than men do. Additionally, the most significant effect of many medical injuries inflicted on women is harm to reproductive capacity, which does not entitle them to receive economic damages, according to a study by the director of the Insurance Law Center at the University of Connecticut School of Law.

- **Rather than facing "runaway litigation," doctors benefit from a claims gap.** A landmark Harvard Medical Practice Study and other studies have found that only a small percentage of medical errors result in lawsuits. Twelve years ago, Harvard researchers found that only one in 7.6 preventable medical errors committed in hospitals resulted in a malpractice claim. Researchers replicating this study made similar findings in Utah and Colorado. From 1996 through 1999, Florida hospitals reported 19,885 incidents but only

3,177 medical malpractice claims. In other words, for every six medical errors only one claim is filed.

- **Malpractice insurance costs amount to only 3.2 percent of the average physician's revenues.** According to experts at the Medicare Payment Advisory Commission (MedPAC), liability insurance premiums make up just a tiny part of a physician's expenses and have increased by only 4.4 percent over the past year. The increase in this expense is noticeable primarily because of the decreases in reimbursements that doctors are receiving from HMOs and government health programs.

- **The small number of claims pursued to a defense verdict are not frivolous.** Researchers at the American Society of Anesthesiologists arranged for pairs of doctors to review 103 randomly selected medical negligence claims files. The doctors were asked to judge whether the anesthesiologist in question had acted reasonably and prudently. The doctors only agreed on the appropriateness of care in 62 percent of the cases; they disagreed in 38 percent of cases. The researchers concluded, "These observations indicate that neutral experts (the reviews were conducted in a situation that did not involve advocacy or financial compensation) commonly disagree in their assessments when using the accepted standard of reasonable and prudent care."

- **No evidence supports the claim that jury verdicts are random "jackpots."** Studies conducted in California, Florida, North Carolina, New York and Ohio have found that jury verdicts bear a reasonable relationship to the severity of the harm suffered. In total the studies examined more than 3,500 medical malpractice jury verdicts and found a consistent relationship between the severity of the injury and the size of the verdict. Uniformly the authors concluded that their findings did not support the contention that jury verdicts are frequently unpredictable and irrational.

- **Empirical evidence does not confirm the existence of "defensive medicine" – and patient injuries refute it.** The Congressional Budget Office was asked to quantify the savings from reduced "defensive medicine" if Congress passed H.R. 4600. This bill, which passed the House in 2002, contained very stringent restrictions on a patient's ability to recover damages. CBO declined, saying that any such "estimates are speculative in nature, relying, for the most part, on surveys of physicians' responses to hypothetical clinical situations, and clinical studies of the effectiveness of certain intensive treatments. Compounding the uncertainty about the magnitude of spending for defensive medicine, there is little empirical evidence on the effect of medical malpractice tort controls on spending for defensive medicine and, more generally, on overall health-care spending. Using broader measures of spending, CBO's initial analysis could find no statistically significant connection between malpractice tort limits and overall health care spending." In addition, numerous studies continue to document preventable medical errors ranging from invasive procedures performed on the wrong patients, medication errors, misreading of test results and unsanitary conditions – all mistakes that any widespread practice of "defensive" medicine could have been expected to reduce.

- **Action could be taken on a national level to reduce medical errors.** The only way to reduce the cost of medical injuries is to reduce negligence – and the best way to accomplish this is by reforming the regulatory oversight of the medical profession. Public Citizen recommends opening up the National Practitioner Data Bank to empower consumers with information about their doctors. It also recommends implementing the "systems approach" advocated by the Institute of Medicine to establish mandatory nationwide error reporting systems, identify unsafe practices and raise performance standards. And Public Citizen recommends that Congress encourage better oversight of physicians through grants to state medical boards, tied to the boards' agreements to meet performance standards.

- **States could improve oversight of health-care providers.** When negligent doctors are disciplined, it is rarely for inferior care. Instead, state medical boards frequently respond to more easily documented things such as prescription drug violations, fraud convictions or disciplinary actions taken in other states. Governance of physicians would improve if medical and licensing boards were required to sever formal links with state medical societies. And legislatures could help ensure that medical boards have enough revenue to hire more investigators and legal staff to perform effective oversight. In addition, Rhode Island is demonstrating how medical errors can be addressed on the state level by considering two bills to reduce overwork among nurses. This is a constructive step, in light of studies that identify fatigue among nurses and medical residents as a significant contributing factor to patient injuries and deaths.

- **State regulators could make insurance rates more predictable.** J. Robert Hunter, Director of Insurance for the Consumer Federation of American, on behalf of Americans for Insurance Reform, has recommended a number of steps to state insurance regulators. These include thoroughly auditing insurance companies' pricing and profitability data; regulating excessive prices; freezing "stressed rates" until prices and jumps in loss reserves can be analyzed; and requiring medical malpractice insurers to use claims history as a rating factor. He also advocates creating a standby public insurer to write risks during "hard markets," and asking the National Association of Insurance Commissioners to stop the implementation of the deregulation of commercial rates and forms, which it is unwisely pushing.

# Medical Misdiagnosis in Texas:
# Challenging the Medical Malpractice Claims of the Doctors' Lobby

## Executive Summary from the Public Citizen's Congress Watch Report
***Full Report available at*** www.citizen.org

The Texas Medical Association and its political allies have made a number of sensational allegations about what they call a malpractice "crisis." We agree that there is a *temporary* "crisis" and malpractice insurance premium costs have spiked over the last two years. But arguments that it has been caused by "frivolous malpractice claims," or "abusive" lawsuits by consumers have no basis in fact.

This Public Citizen study, which examined statistics from numerous government agencies and other reputable sources, has two principal findings:

1) The most significant, long-term malpractice "crisis" faced by Texans is the unreliable quality of medical care being delivered by a relatively small proportion of doctors – a problem that health-care providers have not adequately addressed. Taking away people's legal rights, as is proposed under a cap on non-economic damages, would only decrease deterrence and reduce the quality of care.

2) Any medical malpractice premium "crisis" in Texas, as in the rest of the country, is not a long-term problem nor has it been caused by the legal system. It is a short-term problem triggered by a brief spike in medical malpractice insurance rates for some physicians. This spike in rates is a result of the cyclical economics of the insurance industry and investment losses caused by the country's economic slowdown.

Highlights of this report include:

- **The cost of medical negligence to Texas patients and consumers is considerable, especially when measured against the cost of malpractice insurance to Texas doctors.** Extrapolating from Institute of Medicine (IOM) findings, we estimate that there are 3,260 to 7,261 preventable deaths in Texas each year that are due to medical errors. The costs resulting from preventable medical errors to Texas residents, families and communities are estimated at $1.3 billion to $2.2 billion each year. But the cost of medical malpractice insurance to Texas doctors is only $421.2 million a year.

- **The total number of Texas malpractice claims has dropped for two consecutive years.** Over the past 10 years for which statistics are available from the State Board of Medical Examiners, Texas saw its greatest number of malpractice claims in 1993 – almost a decade ago. This number fluctuated in subsequent years, reaching its second highest point in 1999, but the number of claims decreased in both 2000 and 2001.

- **"Repeat offender" doctors are responsible for the bulk of malpractice payments.** According to the federal government's National Practitioner Data Bank, which covers malpractice judgments and settlements since September 1990, 6.5 percent of Texas doctors have made two or more malpractice payments to patients. These repeat offender doctors are responsible for 51.3 percent of all payments. Overall, they have paid out more than $1 billion in damages. Even more disturbing, just 2.2 percent of Texas doctors (845), each of whom has paid three or more malpractice claims, are responsible for 24.9 percent of all payments.

- **Repeat offender doctors suffer few consequences in Texas.** The Texas state government and the state's health-care providers have done little to rein in those doctors who repeatedly commit negligence. According to the National Practitioner Data Bank and Public Citizen's analysis of NPDB data, disciplinary actions have been few and far between for Texas physicians. Only 15.5 percent of those doctors who made four or more malpractice payments have been disciplined by the Texas State Board of Medical Examiners. Only 25.4 percent of those doctors who made six or more malpractice payments were disciplined.

- **Where's the doctor watchdog?** Texas ranks 32nd among all 50 states and the District of Columbia when its diligence in taking disciplinary action against doctors is measured. The rate of serious actions by the Texas State Board of Medical Examiners in 2001 – 2.5 per 1,000 physicians – is barely one-quarter of the rate in Arizona, the top-ranked state with 10.5 serious actions per 1,000 physicians.

- **Texas provides incomplete reports about doctor mistakes and offenses.** The Texas State Board of Medical Examiners provides only limited information about doctors who have committed offenses or medical errors. This shortcoming is highlighted when the information it provides is compared with reports developed for Public Citizen's own website, www.questionabledoctors.org.

- **No exodus of physicians from Texas is evident.** Although the Texas Medical Association has circulated an unsubstantiated estimate that more than half of the state's doctors plan to quit practicing in response to rising malpractice premiums, official state statistics show that the number of doctors in Texas has been increasing steadily. Between 1997 and 2002, the number of physicians and osteopaths practicing in Texas increased from 31,459 to 37,188 – an increase of 18.2 percent.

- **The spike in medical liability premiums was caused by the insurance cycle, not by "skyrocketing" malpractice awards.** J. Robert Hunter, one of the country's most knowledgeable insurance actuaries and director of insurance for the Consumer Federation of America, recently analyzed the growth in medical liability premiums. He found that amounts charged for premiums do not track losses paid, but instead rise and fall in concert with the state of the economy. When the economy booms and investment returns are high, companies maintain premiums at modest levels; however, when the economy falters and interest rates fall, companies increase premiums.

- **Financial management problems at major insurers compounded Texas' malpractice worries.** Pressure on physicians' premiums intensified during 2001 and 2002

as the number of malpractice insurers in Texas dropped from 17 to four. In at least three noteworthy cases, the departing companies had severe cash-flow problems that went beyond their medical liability businesses.

- **Insurance companies and their lobbyists admit caps on damages won't lower malpractice premiums.** Caps on damages for pain and suffering will significantly lower awards paid to catastrophically injured patients. But because such truly severe cases comprise a small percentage of medical malpractice claims, and because the portion of the insurance premiums that pay for compensation is dwarfed by the portion that pays for defense lawyer fees, caps do not lead to lower premiums. Insurance companies and their lobbyists understand this, and have said so on numerous public occasions.

- **Rather than facing "runaway litigation," doctors benefit from a claims gap.** A landmark Harvard Medical Practice Study and other studies have found that only a small percentage of medical errors result in lawsuits. Twelve years ago, Harvard researchers found that only one in 7.6 preventable medical errors committed in hospitals resulted in a malpractice claim. Researchers replicating this study made similar findings in Utah and Colorado. From 1996 through 1999, Florida hospitals reported 19,885 incidents but only 3,177 medical malpractice claims. In other words, for every six medical errors only one claim is filed.

- **Malpractice insurance costs amount to only 3.2 percent of the average physician's revenues.** According to experts at the Medicare Payment Advisory Commission (MedPAC), liability insurance premiums make up just a tiny part of a physician's expenses and have increased by only 4.4 percent over the past year. The increase in this expense is noticeable primarily because of the decreases in reimbursements that doctors are receiving from HMOs and government health programs.

- **The small number of claims pursued to a defense verdict are not frivolous.** Researchers at the American Society of Anesthesiologists arranged for pairs of doctors to review 103 randomly selected medical negligence claims files. The doctors were asked to judge whether the anesthesiologist in question had acted reasonably and prudently. The doctors only agreed on the appropriateness of care in 62 percent of the cases; they disagreed in 38 percent of cases. The researchers concluded, "These observations indicate that neutral experts (the reviews were conducted in a situation that did not involve advocacy or financial compensation) commonly disagree in their assessments when using the accepted standard of reasonable and prudent care."

- **So-called "non-economic" damages are real and not awarded randomly.** "Non-economic" damages aren't as easy to quantify as lost wages or medical bills, but they compensate the pain and suffering that accompany any loss of normal functions (e.g. blindness, paralysis, sexual dysfunction, lost bowel and bladder control) and inability to engage in daily activities or to pursue hobbies, such as hunting and fishing. This category also encompasses damages for disfigurement and loss of fertility. According to the PIAA, the average total payment between 1985 and 2001 for a "grave injury," which encompasses paralysis, was only $454,454.

- **Capping damages hurts women the most.** Limiting medical malpractice awards for non-economic injury has a disproportionate impact on women. The largest part of economic damages in many tort claims is lost wages, and women earn on average less money than men. Second, the most significant effect of many medical injuries inflicted on women is harm to reproductive capacity, which does not entitle them to receive economic damages, according to a study by the director of the Insurance Law Center at the University of Connecticut School of Law.

- **No evidence supports the claim that jury verdicts are random "jackpots."** Studies conducted in California, Florida, North Carolina, New York and Ohio have found that jury verdicts bear a reasonable relationship to the severity of the harm suffered. In total the studies examined more than 3,500 medical malpractice jury verdicts and found a consistent relationship between the severity of the injury and the size of the verdict. Uniformly the authors concluded that their findings did not support the contention that jury verdicts are frequently unpredictable and irrational.

- **Empirical evidence does not confirm the existence of "defensive medicine" – and patient injuries refute it.** The Congressional Budget Office was asked to quantify the savings from reduced "defensive medicine" if Congress passed H.R. 4600. This bill, which passed the House in 2002, contained very stringent restrictions on a patient's ability to recover damages. CBO declined, saying that any such "estimates are speculative in nature, relying, for the most part, on surveys of physicians' responses to hypothetical clinical situations, and clinical studies of the effectiveness of certain intensive treatments. Compounding the uncertainty about the magnitude of spending for defensive medicine, there is little empirical evidence on the effect of medical malpractice tort controls on spending for defensive medicine and, more generally, on overall health-care spending. Using broader measures of spending, CBO's initial analysis could find no statistically significant connection between malpractice tort limits and overall health care spending." In addition, numerous studies continue to document preventable medical errors ranging from invasive procedures performed on the wrong patients, medication errors, misreading of test results and unsanitary conditions – all mistakes that any widespread practice of "defensive" medicine could have been expected to reduce.

# Medical Misdiagnosis in West Virginia: Challenging the Medical Malpractice Claims of the Doctors' Lobby

## Executive Summary from the Public Citizen's Congress Watch Report

***Full Report available at www.citizen.org***

The West Virginia State Medical Association and its allies have made a number of sensational allegations about what they call a malpractice "crisis." We agree that there is a *temporary* "crisis" and malpractice insurance costs have spiked over the last two years. But claims that it has been caused by "many frivolous lawsuits," an "out-of-control legal system," "an irrational lottery," or "astronomic jury verdicts" have no basis in fact.

This Public Citizen study, which examined statistics from numerous government agencies and other reputable sources, has two principal findings:

1) The medical malpractice "crisis" in West Virginia, as in the rest of the country, is not a long-term problem nor has it been caused by the legal system. It is a short-term problem triggered by a brief spike in medical malpractice insurance rates for some physicians. This spike in rates is a result of the cyclical economics of the insurance industry and investment losses caused by the country's economic slowdown.

2) A more significant, longer-term malpractice "crisis" faced by West Virginians is the unreliable quality of medical care being delivered – a problem that health care providers have not adequately addressed. Taking away people's legal rights, as is proposed under a cap on non-economic damages, would only decrease deterrence and reduce the quality of care.

Highlights of this report include:

- **The cost of medical negligence to West Virginia's patients and consumers is considerable, especially when measured against the cost of malpractice insurance to West Virginia's doctors.** Extrapolating from Institute of Medicine findings, we estimate that medical errors cause 283 to 630 preventable deaths in West Virginia each year. The cost resulting from preventable medical errors to West Virginia's residents, families, and communities is estimated at $109 million to $186 million each year. But the cost of medical malpractice insurance to West Virginia's doctors is less than $77 million a year.

- **Government data show that the median amount of medical malpractice awards in West Virginia has decreased, even as the cost of health insurance has increased.** Statistics from the federal government's National Practitioner Data Bank (NPDB) show the median medical malpractice payment in West Virginia through the first nine months of 2002 was $145,000. This is the same amount that it was in 1997. During that same time period, the national average premium for single health insurance coverage

increased 39 percent (9.5 percent a year). Payments for health care costs, which directly affect health insurance premiums, make up the lion's share of most medical malpractice awards. In spite of this, payments to malpractice claimants in West Virginia have remained steady.

- **Large malpractice verdicts in West Virginia are decreasing.** The number of large jury verdicts in West Virginia medical malpractice cases is steadily decreasing. There were only two verdicts for more than $1 million in 2000 and 2001 – and none reported for 2002.

- **At the height of the purported malpractice "crisis," the number of licensed physicians in West Virginia actually *increased* slightly.** The claim that skyrocketing malpractice insurance premiums are driving doctors from the state is contradicted by the facts. According to the West Virginia State Medical Board and the Board of Osteopathy, 4,069 physicians/osteopaths were practicing in West Virginia during 2001, and the number increased to 4,077 in 2002. Over the past five years, the number of doctors licensed and residing in West Virginia increased by 9.6 percent, a trend mirrored nationwide.

- **"Repeat offender" physicians are responsible for the bulk of malpractice costs.** The NPDB shows that 9.3 percent of doctors who have paid multiple (two or more) malpractice claims are responsible for 62.2 percent of all payments. Even more surprising, only 3.5 percent of West Virginia's doctors – those who have made three or more payments – are responsible for 36.5 percent of all payments. West Virginia ranks third worst among all 50 states and the District of Columbia in terms of its percentage of repeat offender doctors – those with three or more malpractice payments.

- **Repeat offender doctors suffer few consequences in West Virginia.** Public Citizen's analysis of NPDB data found that only 25.5 percent of those doctors who made five or more malpractice payments were disciplined by West Virginia's State Board of Medicine. And only 14.3 percent of doctors – one out of seven – who made 10 or more malpractice payments were disciplined.

- **Where's the doctor watchdog?** West Virginia's State Board of Medicine is lenient with doctors, as are most state medical boards, regularly letting serious and sometimes repeat offenders off the hook. Nationally in 2001, there were 3.36 serious actions taken for every 1,000 physicians. West Virginia took 4.89 serious actions per 1,000 doctors – slightly greater than the national average, but still half as good as the best performing states and not nearly high enough to prevent bad doctors from practicing.

- **Insurance costs are increasing overall, not just for malpractice.** The same cyclical economic forces that pushed up malpractice premiums in West Virginia also influenced the costs of other categories of insurance. In 2001-2002, increases for medical malpractice insurers ranged from 17.9 percent to 26.4 percent in West Virginia. Rate increases for health insurance in the state varied between 20.7 and 23 percent in 2002. And increases in homeowners insurance premiums ranged from 5.8 percent to 27.5 percent.

- **The spike in medical liability premiums was caused by the insurance cycle, not by "skyrocketing" malpractice awards.** J. Robert Hunter, one of the country's most knowledgeable insurance actuaries and director of insurance for the Consumer

Federation of America, recently analyzed the growth in medical liability premiums. He found that amounts charged for premiums do not track losses paid, but instead rise and fall in concert with the state of the economy. When the economy booms and investment returns are high, companies maintain premiums at modest levels; however, when the economy falters and interest rates fall, companies increase premiums.

- **Insurer mismanagement compounded the problems.** Underpriced premiums, reckless cash-flow policies, and ill-fated involvement with Enron and asbestos subsidiaries forced one major carrier, the St. Paul Companies, to stop offering malpractice insurance. The company had covered nearly 29 percent of West Virginia's doctors. According to a *Wall Street Journal* analysis, St. Paul had generated large cash reserves by raising rates during the 1980s, and then released $1.1 billion from reserves between 1992 and 1997 – dramatically boosting its bottom line. This artificial profitability attracted numerous, smaller competitors into the malpractice insurance market and led to widespread price-cutting. By the end of the 1990s, revenue from premiums no longer could cover malpractice claims, causing some companies to collapse and others, like St. Paul, to drop coverage.

# Reports on Two Other Medical Malpractice "Crisis" States: Mississippi and Nevada

# Medical Misdiagnosis in Mississippi

## Introduction

In Mississippi, changes in medical malpractice were lumped into a broad, pro-business agenda that sought to make it harder for consumers to collect damages from everyone—from manufacturers and small-business owners to auto dealers and doctors. A statewide coalition, representing 40 different associations, derisively mocked the Mississippi tort system as "jackpot justice" and put forth 42 different bills during the 2002 legislative session.

When the session ended in April, tort "reform" had gone 0-for-42.[1] It was only when legislators were called back in September for an 83-day special session that changes were enacted to the Mississippi civil-justice system. The changes in malpractice law included placing caps on non-economic damages, holding physicians responsible only for their portions of non-economic damages, and requiring that lawsuits be filed in the county where the medical malpractice occurred.

The new laws took effect on Jan. 1, 2003. Although physicians had described the increase in malpractice rates in desperate terms, the president-elect of the Mississippi State Medical Association expressed only modest ambition for the new system. It may help to stabilize the market, Dr. George McGee told the *Sun Herald* newspaper in August. "It may not translate into premium reductions."[2]

## Assumptions vs. realities

As it did in many states, the December 2001 decision by the St. Paul Companies, Inc. to cease offering liability coverage to doctors triggered the immediate talk of a malpractice insurance "crisis" in Mississippi. St. Paul was one of the top three malpractice insurance carriers in the state and covered 427 doctors.[3]

Pointing to this development, the president of the Mississippi Medical Association reported that doctors statewide alleged that lawsuits were making it difficult for them to obtain insurance coverage.[4] Lawsuits, however, had little to do with the departure of the St. Paul Companies from the marketplace. An analysis by the Wall Street Journal made these points about the decline in the medical liability insurance market:

- Some insurance carriers "rushed into malpractice coverage because an accounting practice widely used in the industry made the areas seem more profitable in the early 1990s than it really was. A decade of short-sighted price slashing led to industry losses of nearly $3 billion last year."

- When malpractice claims increased in the 1980s, St. Paul and its competitors sharply raised rates. But, as the frequency and size of claims leveled off, St. Paul realized it had set too much money aside for malpractice payments. The company then released $1.1 billion from its reserves between 1992 and 1997, which dramatically boosted its bottom line.

- St. Paul's apparent profitability attracted numerous, smaller carriers into the malpractice insurance market, which led to widespread, competitive price-cutting.

- By the end of the 1990s, the revenue from premiums decreased to the point that insurers no longer could cover malpractice claims. Some collapsed and others, like St. Paul, withdrew from the market. [5]

The centerpiece in the malpractice liability package passed by Mississippi's Legislature was a $500,000 cap on non-economic damages – a limit scheduled to increase to $750,000 in 2011 and to $1 million after 2017. But an examination of malpractice awards and current malpractice insurance rate problems in Mississippi shows almost no direct linkage between the two.

In August 2002, the *Sun Herald* newspaper published an in-depth report on the malpractice insurance showdown, relying on data available from the Board of Medical Licensure, the state Medical Association and other sources. Its findings included:[6]

- Although premiums had increased dramatically for some medical specialists, across the board, Mississippi's malpractice rates increased about 15 percent during 2002 – not higher than many other states, including those with caps on awards.

- In 2001, Medical Assurance Co. of Mississippi had 397 lawsuits, but paid out on only 73, according to the company's records. It paid out an average of $261,194 per claim – well below the state's new cap.

- Since lawsuits reportedly began escalating in 1995, there has been only one mega-award against a medical provider in Mississippi – a $23 million award against a medical center where a baby was dropped at childbirth and suffered permanent brain damage.

Rates that are being requested and approved for other forms of insurance in Mississippi indicate that malpractice insurance is part of a broader trend of rising insurance costs.

- In January 2003, the Mississippi Insurance commissioner approved a 19.9 percent increase statewide for State Farm homeowner policy premiums – with a 25 percent hike approved for homeowners in the coastal regions. A month earlier, the insurance company had requested a 42.5 percent statewide increase.[7]

- In September 2002, Aetna proposed rate increases of about 25 percent for one group of policyholders in Hinds County, Ms. A year earlier, Aetna had sought a 41 percent increase in premium rates.[8]

### The costs of medical malpractice in Mississippi

The true impact of medical malpractice in Mississippi should be measured by the cost to consumers, not the premiums paid by doctors to their insurance companies. Consider these facts:

Estimated preventable deaths annually in Mississippi due to medical errors: 445-991
Estimated annual costs in Mississippi resulting from preventable medical errors:
$172-293 million
Cost of Mississippi doctors' medical malpractice premiums paid in 2000: $35.4 million.[9]

### A questionable accomplishment

- The public relations and advertising campaigns that pushed for changes in Mississippi's malpractice laws made it clear that businesses and physicians placed a high priority on this accomplishment. What is not clear, however, is what other – if any – tangible results they achieved.

- Early last year, 474 Mississippi physicians published full-page newspaper ads in which they labeled the state "Litigation Central," and melodramatically claimed, "Our legal climate has a disease no physician can cure. The cure is in the hands of the Mississippi Legislature."[10]

- In May 2002, the U.S. Chamber of Commerce joined in the criticism of Mississippi's lack of tort-reform, claiming it had created a bad business climate. During this same time, studies were showing the state was scoring great successes in industrial recruitment and retention.[11]

- When doctors took their malpractice pleas public, doctors from Gulfport Memorial Hospital bought newspaper ads to warn patients that they might be unable to remain in business without insurance coverage. Within weeks, however, all but one of the physicians had been able to replace their malpractice policies.[12]

- While Mississippi still ranks nearly last among states in the number of doctors per capita,[13] it has made dramatic gains since 1995. In fact, only four states have had faster increases in their number of physicians.[14]

In the end, it appears Mississippi political and medical leaders pursued a central tactic: limiting the amount of money patients can collect after they have been injured by medical errors. This narrowly focused change, however, did nothing to address the central challenge of reducing liability payments by reducing medical errors.

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[1] Joey Bunch, "Crisis or PR campaign," *The Sun Herald*, Biloxi, Ms., Aug. 11, 2002
[2] Id.
[3] Patrice Sawyer, "Tort reform: Where's the crisis?" *Clarion-Ledger*, Jackson, Ms., Jan. 31, 2002.
[4] Id.
[5] Rachel Zimmerman and Christopher Oster, "Insurers' Missteps Helped Provoke Malpractice 'Crisis,'" *Wall Street Journal,* June 24, 2002.
[6] Joey Bunch, "Crisis or PR campaign," *The Sun Herald*, Biloxi, Ms., Aug. 11, 2002
[7] Timothy Boone, "State Farm granted smaller rate hike," *The Sun Herald,* Biloxi, Ms., Jan. 4, 2003.
[8] Thyrie Bland, "Aetna proposal could reduce county staffers' bottom line," *Clarion-Ledger*, Jackson, Ms., Sept. 4, 2002.
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[10] Jerry Mitchell, "Doctors taking fight over suits to Capitol," *Clarion-Ledger*, Jackson, Ms., Jan. 16, 2002.
[11] Joey Bunch, "Crisis or PR campaign," *The Sun Herald*, Biloxi, Ms., Aug. 11, 2002.
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[13] Kaiser Family Fund, St Kaiser Family Foundation, available at www.statehealthfacts.kff.org/
[14] Id.

# Medical Misdiagnosis in Nevada

## Introduction

Nevada began 2002 with political and medical leaders proclaiming a "malpractice crisis" in the state – especially in Southern Nevada, where Las Vegas is located. By October, an emergency session of the Legislature enacted several changes in Nevada's tort laws, placing limits on the amount injured patients can receive for pain and suffering and creating a $50,000 cap on damages against hospitals and physicians who treat trauma patients. None of the changes, however, effectively addressed the need to reduce the rate at which patients are harmed by substandard medical care in Nevada.

Nevada ended 2002 with little good to show for the changes it had rushed into place. Malpractice premiums remained high, numerous physicians – especially those in high-risk specialties – were still threatening to leave the state, and a doctor-led referendum movement had pronounced Nevada's tort reform efforts a failure.

## Assumptions vs. realities

Doctors and politicians in Nevada adopted their crisis mentality shortly after the state's leading provider of malpractice insurance, the St. Paul Companies, Inc. announced in December 2001 that it would no longer make liability coverage available to doctors. Health professionals and insurance industry representatives were quick to assign blame for the problem, as the Las Vegas *Review-Journal* reported, claiming that "insurance rates are rising because there are too many frivolous medical malpractice lawsuits and there is no cap on the amount of money juries can award."[1]

In fact, the decision by the St. Paul Companies had more to do with its reckless cash flow policies than it did with jury awards. A *Wall Street Journal* analysis of the decline in the medical liability insurance market made these points[2]:

- Some insurance carriers "rushed into malpractice coverage because an accounting practice widely used in the industry made the areas seem more profitable in the early 1990s than it really was. A decade of short-sighted price slashing led to industry losses of nearly $3 billion last year."

- When malpractice claims increased in the 1980s, St. Paul and its competitors sharply raised rates. But, as the frequency and size of claims leveled off, St. Paul realized it had set too much money aside for malpractice payments. The company then released $1.1 billion from its reserves between 1992 and 1997, which dramatically boosted its bottom line.

- St. Paul's apparent profitability attracted numerous, smaller carriers into the malpractice insurance market, which led to widespread, competitive price-cutting.

- By the end of the 1990s, the revenue from premiums decreased to the point that insurers no longer could cover malpractice claims. Some collapsed and others, like St. Paul, withdrew from the market.

Within six weeks of the announcement by the St. Paul Companies, Nevada Gov. Kenny Guinn, met behind closed doors with a small group of physicians and reached the swift conclusion that the state should impose caps on malpractice awards.[3]

But a detailed look at malpractice insurance problems in Nevada shows that claims by patients were singled out inappropriately.

- From 1997 through 2001, the mean number of payments made annually to cover malpractice claims in Nevada was 89 – exactly the number reported for 2001. In other words, state declared its crisis following a year in which the annual number of malpractice payments was not extreme. (In fact, there was a decline in this annual number between 2000 and 2001.)[4]

- In Clark County, which includes the fast-growing Las Vegas area, there had been no extreme escalation of malpractice lawsuits filed. According to District Court records, 133 suits were filed in 1998, 148 were filed in 199 and 158 were filed in 2000. Of the cases filed in 2000, only 17 went to a jury trial and the remainder were dismissed or settled out of court.[5]

- Although physicians in Las Vegas experienced the same kinds of rate increases as doctors in many metropolitan areas, they were paying substantially less than the highest rates within their specialties[6]:

  **Sample of annual 2002 premiums paid by general surgeons:**
  Miami (Dade County), Fla. - $174,268
  Detroit, Mich. - $107,139
  Las Vegas (Clark County), Nev. - $85,056
  Chicago (Cook County), Ill. - $75,630
  Cleveland, Ohio - $74,554
  New York (Nassau/Suffolk counties), N.Y. - $65,870

  **Sample of annual premiums paid by obstetricians-gynecologists**:
  Miami (Dade County), Fla. - $210,576
  Cleveland, Ohio - $152,496
  Las Vegas (Clark County), Nev. - $141,760
  Detroit, Mich. - $140,917
  New York (Nassau/Suffolk counties), N.Y. - $115,431
  Chicago (Cook County), Ill. - $110,091
  Brownsville, Laredo, El Paso (Rio Grande Valley), Texas - $97,830

### The costs of medical malpractice in Nevada

The true impact of medical malpractice in Nevada should be measured by the cost to consumers, not the premiums paid by doctors to their insurance companies. Consider these facts:

Estimated preventable deaths annually in Nevada due to medical errors: 312-696
Estimated annual costs in Nevada resulting from preventable medical errors:
$121-206 million
Cost of Nevada doctors' medical malpractice premiums paid in 2000: $50.8 million.[7]

- Medical negligence was not the only form of insurance for which rates have been rising dramatically in Nevada. Sierra Health Service, which has 55 percent of the statewide market for health insurance, forecasts double-digit increases for most of its client groups this year – and increases as high as 20 percent for some.[8]

### Pressure for a misdirected solution

Physicians in Nevada took drastic, overt steps to pressure the state's political leaders to respond to the malpractice insurance crisis by emphasizing caps on jury awards.

- Southern Nevada's only trauma center shut down for 10 days, July 3 through July 13, when dozens of doctors resigned over liability concerns. These physicians objected when politicians described them as "striking workers," but most had not stopped working at other hospitals during the trauma center's closure.[9]

- Threats by physicians to close their practices or leave the state in reaction to insurance costs are particularly potent in Nevada, which gained population at a rate of 66 percent between 1990 and 2000, but ranks only 46th in the nation for its number of doctors per 100,000 population.[10]

- In April, the executive director of the Nevada State Medical Association told a legislative committee that 100 physicians were poised to leave the state in coming months in reaction to increasing insurance premiums.[11]

- Doctors sponsored a $1 million campaign of newspaper ads encouraging public support for tort reform.[12]

- In a related matter, the District Attorney's office opened an investigation into possible legal violations associated with a paid political advertisement supporting tort "reform," published by the top administrator at the publicly funded University Medical Center in Las Vegas.[13]

### Tort "reform" gets a failing grade

The Nevada Legislature met in a four-day special session at the end of July and enacted changes in its tort system that[14]:

- Placed a $350,000 cap on non-economic damages in most cases.

- Placed a $50,000 limit on damages for hospitals and physicians treating trauma patients.

- Holds doctors financially liable only for the damages for which they are responsible.

- Allows judgments to be paid over time.

By most measurements, however, these responses to Nevada's malpractice insurance problems have been ineffective.

- One month after the new medical liability laws took effect, at least 20 Las Vegas obstetricians still were making plans to leave the state or abandon their practices. Doctors complained that tort reform had not succeeded in reducing their malpractice premiums.[15]

- The new medical liability laws will not halt the exodus of physicians from the state or ensure consumer's access to medical care, according to a report by a legislative analyst hired by a physician-led group, "Keep Our Doctors in Nevada." The organization is circulating initiative petitions to dump the recent changes and try again.[16]

- In the process of proposing solutions to the malpractice problems, Gov. Kenny Guinn rejected suggestions that Nevada make it easier to weed out bad doctors. The governor and lawmakers did not support efforts to allow consumers to see complaints filed against doctors or to learn of disciplinary actions taken by hospitals against staff physicians.[17]

### Missed opportunity

The decision to allow only voluntary and confidential reporting of medical errors and complaints against doctors reflects Nevada's determination to reduce payments to injured patients – but not to reduce the likelihood that patients will be harmed by substandard care.

- In the words of Dr. Bernard Feldman, member of a legislative subcommittee established to study a system for reporting medical errors, "There is no evidence this kind of voluntary system will reduce medical errors." He also questioned whether hospitals would voluntarily comply with a request to report medical errors to a public registry.[18]

- An opportunity exists in Nevada to reduce medical liability payments through better policing of the state's worst doctors. As a case in point, one of Nevada's worst doctors surrendered his license and moved to California at the end of June 2001. Orthopedic surgeon Francis G. D'Ambrosio was sued five times during 2001 – a rate that a local newspaper called a "record" for Clark County. In two of the cases, he was accused of turning older patients into paraplegics.[19]

CBSNews reported that by the time D'Ambrosio arrived in California, he had amassed a record of 39 lawsuits, 21 settlements and "was already building his reputation as the most sued surgeon in Nevada." And to make matters worse, "Nevada's medical board didn't post D'Ambrosio's record until June of this year [2002] after its investigation was done. More than a year after he'd surrendered his Nevada license."[20]

[1] Joelle Babula, "Insurance costs driving doctors away," *Review-Journal,* Jan. 23, 2002.
[2] Rachel Zimmerman and Christopher Oster, "Insurers' Missteps Helped Provoke Malpractice 'Crisis,'" *Wall Street Journal,* June 24, 2002.
[3] Joelle Babula, "Guinn eyes cap on jury awards to avert crisis," *Review-Journal,* Jan. 24, 2002.
[4] National Practitioner Data Bank, 2001.
[5] Joelle Babula, "Insurance costs driving doctors away," *Review-Journal,* Jan. 24, 2002.
[6] *AMNews,* Oct. 28, 2002.
[7] Preventable deaths and costs data from, To Err is Human, Building a Safer Health System, Institute of Medicine, 1999. The range of preventable deaths and costs resulting from medical errors are prorated based on each state's share of overall U.S. population in 2000. Population statistics for 2000 from the Census Bureau. *Statistical Compilation of Annual Statement Information for Property/Casualty Insurance Companies in 2000,* National Association of Insurance Commissioners.
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[16] Joelle Babula, "Analysis finds laws won't keep doctors in state," *Review-Journal,* Oct. 16, 20, 2002.
[17] Ed Vogel, "Bill does not allow public to see complaints against doctors," *Review-Journal,* July 31, 2002.
[18] Ed Vogel, "Bill does not allow public to see complaints against doctors," *Review-Journal,* July 31, 2002.
[19] Chris Di Edoardo, "Las Vegas surgeon subject of multiple lawsuits," *Review-Journal,* March 4, 2002.
[20] CBSNews.com, Nov. 19, 2002

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF PHYSICIANS-AMERICAN SOCIETY OF INTERNAL MEDICINE

The American College of Physicians-American Society of Internal Medicine (ACP-ASIM)—representing 115,000 physicians and medical students—is the largest medical specialty society and the second largest medical organization in the United States. We congratulate the House Committee on the Judiciary for holding this important hearing on a subject matter that has more relevance today than ever before. Of the College's top priorities for 2003, addressing the health care liability crisis and its impact on access to care is one of the most critical to our members. ACP-ASIM wishes to thank Committee Chairman Jim Sensenbrenner, Jr., Committee Ranking Member John Conyers, Jr., and other members, for holding this important hearing to discuss the immediate need to enact meaningful medical liability reform.

BACKGROUND

Doctors across the country are experiencing sticker shock when they open their medical malpractice insurance renewal notices—if they even get a renewal notice. After more than a decade of generally stable rates for professional liability insurance, physicians have seen costs dramatically increase in 2000–2003. And in some areas of the country, premiums have soared to unaffordable levels. According to the *Medical Liability Monitor*, in mid-2001, insurance companies writing in 36 states and the District of Columbia claim to have raised rates well over 25 percent. Unfortunately, rates continue to rise dramatically with no sign of the market beginning to stabilize.

While obstetricians, surgeons and other high-risk specialists have been hit hard, internists have been one of the hardest hit specialties—having seen a record nearly 50 percent average increase over the last two years. In some cases, physicians, even those without a track record of lawsuits, cannot find an insurance company willing to provide coverage. These physicians are being forced to decide whether to dig deeper and pay the steeper bill, change carriers, move out of state, or retire from the practice of medicine.

Of these options, changing carriers may not even be an alternative. Finding replacement coverage won't be as easy as it was in a buyer's market. Companies writing professional liability coverage are fleeing or being chased from the market. As an example, St. Paul Companies, which insures doctors in 45 states and is the second largest medical underwriter in the country, announced late in 2001 that it no longer would write medical liability policies. It plans to phase out coverage as physicians contracts expire over the next 18 to 24 months. Frontier and Reliance are also gone. Other commercials, such as PHICO, CNA and Zurich, are significantly cutting back. Even some provider-owned insurers, committed to this market by their founders, are pulling back from some states in which they extended sales.

THE PERFECT STORM

At a time when the market is squeezing physician and hospital margins, the rise in professional liability insurance may be the deciding factor that contributes to whether physician offices and emergency rooms keep their doors open. Recently, the costs of delivering health care have been driven by increased costs of new technologies; increased costs of drugs that define the standard of care acceptable for modern medicine; the rising costs of compliance under increasing state and federal regulation; the low reimbursement rate under Medicare and Medicaid; and the declining fees from managed care have all been contributing factors that have affected patient access to health care.

Unquestionably, there is real potential that rising insurance rates ultimately will reduce access to care for patients across the country. Indeed, press accounts on a daily basis are demonstrating exactly that from coast to coast. Physician offices and emergency rooms have been closing their doors all across the country due to the exorbitant costs. The states most severely hampered by the spiraling out-of-control rates are: Florida, Georgia, Illinois, Michigan, Mississippi, Nevada, New Jersey, New York, Ohio, Oregon, Pennsylvania, Texas, Washington, and West Virginia. Several other states are just beginning to feel the impact.

Some states have tried to address the dramatic increase in professional medical liability insurance rates with very little success. At best, attempts by the states to solve this problem have resulted in only band-aid approaches to the more underlying problem: the escalation of lawsuit awards and the expense of litigation has led to the increase in medical liability premiums. This fact has resulted in many patients not receiving or delaying much needed medical care—a fact Congress can no

longer ignore. ACP-ASIM strongly believes that Congress must act to stabilize the market to avoid further damage to the health care system.

RELIEF FOR PHYSICIANS FROM SOARING MALPRACTICE PREMIUMS

Federal legislation has been introduced in the 108th Congress to help curb the spiraling upward trend in malpractice premiums. *H.R. 5, the "Help Efficient, Accessible, Low Cost, Timely Health Care" (HEALTH) Act of 2003, will attempt to safeguard patient access to care, while continuing to ensure that patients who have been injured through negligence are fairly compensated. ACP-ASIM strongly endorses this legislation as a means to stabilize the medical liability insurance market and bring balance to our medical liability litigation system.* The HEALTH Act achieves this balance through the following common sense reforms:

- Limit on pain and suffering (non-economic) awards. This requirement limits unquantifiable non-economic damages, such as pain and suffering, to no more than $250,000.
- Unlimited recovery for future medical expenses and loss of future earnings (economic) damages. This provision does not limit the amount a patient can receive for physical injuries resulting from a provider's care, unless otherwise restricted by state law.
- Limitations on punitive damages. This requirement appropriately raises the burden of proof for the award of quasi-criminal penalties to "clear and convincing" evidence to show either malicious intent to injure or deliberate failure to avoid injury. This provision does not cap punitive damages, rather, it allows punitive damages to be the greater of two times the amount of economic damages awarded or $250,000.
- Periodic payment of future damages. This provision does not reduce the amount a patient will receive. Rather, past and current expenses will continue to be paid at the time of judgment or settlement while future damages can be funded over time. This ensures that the plaintiff will receive all damages in a timely fashion without risking the bankruptcy of the defendant.
- Elimination of double payment of awards. This requirement provides for the jury to be duly informed of any payments (or collateral source) already made to the plaintiff for her injuries.
- A reasonable statute of limitation on claims. This requirement guarantees that health care lawsuits will be filed no later than 3 years after the date of injury, providing health care providers with ample access to the evidence they need to defend themselves. In some circumstances, however, it is important to guarantee patients additional time to file a claim. For example, the legislation extends the statue of limitations for minors injured before age 6.
- A sliding scale for contingency fees. This provision will help discourage baseless and frivolous lawsuits by limiting attorney incentives to pursue meritless claims. Without this provision, attorneys could continue to pocket large percentages of an injured patient's award, leaving patients without the money they need for their medical care. The sliding scale would look something like this:
  - —Forty percent (40%) of the first fifty thousand dollars recovered
  - —Thirty-three and one-third percent (33 1/3%) of the next fifty thousand dollars recovered
  - —Twenty-five percent (25%) of the next five hundred thousand dollars recovered
  - —Fifteen percent (15%) of any amount recovered in excess of six hundred thousand dollars
- Proportionate liability among all parties. Instead of making a party responsible for another's negligent behavior, this requirement ensures that a party will only be liable for his or her own share. Under the current system, defendants who are only 1 percent at fault may be held liable for 100 percent of the damages. This provision eliminates the incentive for plaintiff's attorneys to search for "deep pockets" and pursue lawsuits against those minimally liable or not liable at all.

These common sense recommendations have been proven to work. The HEALTH Act is largely based on provisions contained in the California Medical Injury Compensation Reform Act (MICRA). Since its enactment in the mid-1970's, the MICRA reforms have helped reduce the overall costs of medical malpractice and have contributed to an increase in patient access to care. During this recent malpractice in-

surance crisis, California's rates have changed only slightly, while other states have spiraled to out of control levels. ACP-ASIM strongly supports the elements contained in MICRA. Further, we believe that any legislation proposed must include these basic, proven elements in order to assure the stabilization of malpractice premiums.

CONCLUSION

ACP-ASIM is pleased that the House Committee on the Judiciary agreed to conduct this important hearing to address the serious problem of soaring medical malpractice premiums that physicians are facing across the country. *We strongly urge the House Judiciary Committee to pass common sense reform contained in the HEALTH Act that would allow for greater access to care, while adequately compensating injured patients.* We thank the Committee and appreciate the opportunity to present our views.

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PREPARED STATEMENT OF THE COLLEGE OF AMERICAN PATHOLOGISTS

The College of American Pathologists (CAP) is pleased to submit this statement for the record of the Committee on the Judiciary hearing on H.R. 5, the Help Efficient, Accessible, Low-Cost, Timely Healthcare Act of 2003. The College is a medical specialty society representing more than 16,000 board-certified physicians who practice clinical or anatomic pathology, or both, in community hospitals, independent clinical laboratories, academic medical centers and federal and state health facilities.

Pathologists, like all physicians, face severe hardships resulting from the worsening medical liability insurance crisis. For many, just finding coverage has been an arduous task at best and, for some, nearly impossible. Those who have found willing insurers are paying substantially higher premiums—in some cases, several times the previous year's rates—for coverage plans, regardless of their claims history.

The realities of this crisis are clear: Pathologists and other physicians can no longer offer certain procedures or are leaving their practices altogether because of the exorbitant costs of malpractice premiums. These are desperate decisions brought on by a tort system with no mechanism to restrain runaway "pain and suffering" and punitive awards. Damages rise beyond reason and, in the end, all patients and providers suffer as the nation's health care costs soar and access to quality care declines.

Real-world examples in the laboratory community highlight the problem:

- The chief executive of a small, rural Pennsylvania hospital recently told a Senate Appropriations subcommittee that he nearly was forced to close the facility when an insurer declined to renew a malpractice policy for his pathologist, a 17-year practice veteran with no claims history. Only through a last-minute joint underwriting agreement was the pathologist able to retain insurance coverage, which allowed the hospital to continue offering laboratory, blood banking and surgical pathology services and remain open, the executive said.
- A pathology group that provides services to all Hawaii's outer island hospitals and five facilities on Oahu—about 20 pathologists, in all—is, like many physician practices, shopping for a new insurance carrier. The group's current insurer recently sent a renewal notice quoting a four-fold increase in premiums compared with 2002 rates.
- In general, malpractice insurance premiums for pathologists have doubled in the past year, reports JLT Services Corp., the College's member insurance broker. In some locations, particularly urban areas, the increases have been significantly higher. Pathologists have been particularly hard hit by The St. Paul Companies' December 2001 decision to leave the medical liability insurance marketplace. The St. Paul, which provided about 9 percent of all malpractice insurance nationwide at the time, had been the underwriter of the CAP-endorsed Professional Liability plan.

Pathologists and other physicians are increasingly hard-pressed to continue providing services, given the heavy burden rising insurance premiums have placed on their practices. Insurance rates of $200,000 or more for some high-risk specialties have forced many physicians to limit services, retire early or move to states where reforms have brought greater stability to premiums. The skyrocketing cost of liabil-

ity insurance comes at a particularly critical time for physicians, who also face a widening gap between Medicare reimbursements and practice costs.

Severe patient access problems brought on by the liability insurance crisis have been documented in at least a dozen states and it is expected that 30 more soon will join that list. In the crisis states, obstetrician-gynecologists have been forced to stop delivering babies, trauma centers have closed and many physicians are grappling with how they can continue to provide other high-risk procedures.

Congress must act now to bring commonsense reforms to America's medical liability system. The CAP strongly supports the approach contained in the HEALTH Act of 2003. This critically important bill, introduced by Rep. Jim Greenwood, R-Pa., would:

- place a reasonable limit ($250,000) on non-economic damages and no limit on economic damages;
- create mechanisms to ensure that only justifiable punitive damages are paid, with a guideline to limit punitive damages to two times economic damages or $250,000, whichever is greater;
- structure settlements to be paid in increments, rather than lump-sum payments, so that expenses are reimbursed as they occur and earnings, as they would have accrued;
- establish a three-year statute of limitations, with special provisions for minors.
- establish criteria to ensure that defendants would pay damages in proportion to their fault;
- ensure that states with damage caps in place would be permitted to retain them; and
- set a sliding scale for attorney contingency fees to discourage frivolous lawsuits.

The HEALTH Act can work because it is modeled on a California law that has worked well for nearly three decades. It was enacted in circumstances much like those the nation faces today. California suffered a meltdown of its health care system in the early 1970s and physicians saw their premiums soar more than 300 percent. Liability carriers left the state and some physicians closed their office doors. The Medical Injury Compensation Reform Act, or MICRA, which came into effect in 1976, provided a $250,000 limit on non-economic damages, unlimited economic damages, a statute of limitations on claims, sliding-scale limits on contingency fees, advance notice requirements before claims were filed, binding arbitration of disputes and periodic payment of future damages.

The effect of this legislation was dramatic. The average liability premiums decreased 40 percent in the 25-year period ending in 2001 (expressed in constant dollars). In 2001, the *Medical Liability Monitor* published data that demonstrated that the average premium paid by California physicians practicing internal medicine, general surgery and obstetrics/gynecology ranged from 43 percent to 51 percent of the average premiums of their counterparts in Florida, Illinois, New York, Texas and Michigan. This was supported by a 53 percent lowering in the dollar amounts of settlements in California, compared with the nation as a whole.

Our current liability crisis is not one of increasing litigation, but one of unreasonably high judgment amounts. Patients are not eager to sue their doctors. In fact, in 1991, the *New England Journal of Medicine* reported that only 1.53 percent of those injured by possible medical actions even file a claim. Severity of awards is the problem, and that is what the HEALTH Act of 2003 is designed to address.

The College supports such reforms to promote the basic goal of ensuring access to a wide range of health care services and promoting patient safety and quality medical care. In particular, the College strongly supports the bill's establishment of limits on non-economic and punitive damages. These provisions, combined with a sliding scale limit on contingency fees, make for a strong, positive step toward reforms that benefit the whole health care system and protect patient access to affordable, quality care.

The CAP appreciates the opportunity to present its views to the Committee on the Judiciary and offers its support and continued assistance as Congress works to meet the challenge posed by the nation's liability insurance crisis.

PREPARED STATEMENT OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

This statement is submitted to the Judiciary Committee on behalf of the 93,400 members of the American Academy of Family Physicians. This hearing, concerning H.R. 5, The Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act, is especially timely. The current lack of professional liability insurance does threaten patient access to care in some states. The continued trend of increasing insurance premiums drives up the cost of health care and forces physicians to drop certain services when they cannot afford professional liability insurance.

PATIENTS AFFECTED BY THE LACK OF MEDICAL LIABILITY INSURANCE

Medical liability insurers have left the medical insurance market in the past year in alarming numbers. One major reason for this exodus is the unpredictable rise in jury awards that exists in states without adequate tort reforms. According to the Physician Insurers Association of America (PIAA), the last decade has seen a dramatic increase in awards in excess of $1 million even while the number of suits filed has remained the same. As a result of the steady rise in record-breaking awards, most insurers find it more difficult to predict their risk. The remaining insurers have raised rates or refused new applications for insurance. Family physicians are beginning to experience difficulty in finding insurance companies to provide liability insurance or are receiving renewal notices with anywhere between 60 percent and 200 percent increases for the second year in a row.

Stories of family physicians closing their practices because of liability insurance premiums are turning up across the U.S. Recently, for example, AAFP Direct reported

that AAFP Past President Neil Brooks, M.D., sent a letter recently to the Hartford Courant, saying that he was giving up his practice of thirty-two years because the liability premiums had become too expensive.

In rural Morrow County, Ohio, Brian Bachelder, M.D., President of the Ohio Academy of Family Physicians, decided to stop delivering babies after his liability premium increased by $21,000 last year. Dr. Bachelder was the only Morrow County physician providing prenatal and obstetrical care.

In rural Chipley, Florida, Greg Sloan M.D., found his malpractice premium has risen from $4,500 to $13,600 in one year. This was in spite of a 24-year career without a suit being filed against him. Dr. Sloan said it has reached the point that he cannot pay his staff and the liability premiums.

Most state laws, hospital accreditation requirements and managed care contracts mandate that physicians carry medical liability insurance. If family physicians cannot afford insurance coverage, they must choose between shutting down their practice altogether or restricting the range of services they provide. For family physicians in rural settings, this usually means being forced to stop delivering babies or providing prenatal care due to mounting liability premiums.

The tools needed to counteract this alarming trend are derived from state experiences. Last year, the Department of Health and Human Services released a report entitled, "Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System." According to this study, liability premiums have been growing rapidly in states that have failed to place reasonable limits on non-economic damages. While economic losses, such as lost wages, medical expenses and rehabilitation costs are fully compensated, non-economic damages reflect the monies collected for intangible losses.

Over the previous two years, states without caps on these non-economic damages have experienced a 44-percent increase in liability premiums. In contrast, states with caps on non-economic damages of $250,000 experienced on average an increase of only 15 percent in medical liability insurance premiums.

The reforms contained in California's Medical Injury Compensation Reform Act of 1975 (MICRA) have already brought stability and fairness to the California legal system for the past 27 years. Californians Allied for Patient Protections (CAPP), a major consumer group supportive of MICRA, found that legal disputes in California are settled 23 percent faster than the national average. At the same time, the number of suits filed in California matches the national average. In the ensuring 27 years, medical liability insurance premiums have risen 505 percent nationwide compared with California's increases of 167 percent.

AAFP SUPPORT FOR H.R. 5, THE HEALTH ACT

But the states cannot, by themselves, resolve this national crisis. The House of Representatives addressed this issue by passing, H.R. 4600, The Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act in the 107th Congress. The

HEALTH Act has been reintroduced into the 108th as H.R. 5. The Academy supports H.R. 5, which would bring the same rational reforms contained in MICRA to all states' professional liability systems. The AAFP supports federal legislation to stabilize the medical tort reform systems in the states since spiraling insurance premiums mean increasing numbers of pregnant women in rural areas of the U.S. will not be able to find a physician to deliver their babies.

There is an important additional reason that the AAFP supports The HEALTH Act. H.R. 5 requires that a party pay damages only to the extent that the party was liable for the harm caused. Family physicians provide primary care which is comprehensive and coordinated care for all life stages and both genders. Because they are the overall medical managers for a vast number of patients in the U.S., with responsibility for making referrals to subspecialists, family physicians need the protections of joint and several liability reforms to ensure that they are not held responsible for the clinical decisions of others.

CONCLUSION

The Academy appreciates the opportunity to support passage of H.R. 5 out of the Judiciary Committee. We look forward to working with the Committee to find a workable solution for patients and physicians.

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PREPARED STATEMENT OF RODNEY C. LESTER

Chairman Sensenbrenner, Jr. and Congressman John Conyers, Jr., I am Rodney C. Lester, CRNA, PhD, President of the American Association of Nurse Anesthetists (AANA). I appreciate the opportunity to submit for the record a statement on issues surrounding medical liability reform, which are the most challenging facing healthcare today.

For those of you who may be unfamiliar with the AANA, we represent approximately 30,000 Certified Registered Nurse Anesthetists (CRNAs) across the United States. In the administration of anesthesia, CRNAs perform virtually the same functions as anesthesiologists and work in every setting in which anesthesia is delivered including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers, health maintenance organizations' facilities, and the offices of dentists, podiatrists, ophthalmologists, and plastic surgeons. Today, CRNAs administer approximately 65% of the anesthetics given to patients each year in the United States. CRNAs are the sole anesthesia provider in at least 65% of rural hospitals, which translates into anesthesia services for millions of rural Americans.

CRNAs have been a part of every type of surgical team since the advent of anesthesia in the 1800s. Until the 1920s, nurses almost exclusively administered anesthesia. In addition, nurse anesthetists have been the principal anesthesia provider in combat areas in every war the United States has been engaged in since World War I. CRNAs provide anesthesia services in the medical facilities of the Department of Defense, the Public Health Service, the Indian Health Service, the Department of Veterans Affairs, and countless other public and private entities. Given the current state of affairs with Iraq and Afghanistan, it is not surprising that our deployed forces depend greatly upon the services and skills of CRNAs.

You may be aware of the widely publicized nursing shortage. While we do not have enough rank and file nurses there is an increasingly acute shortage of CRNAs. Quite simply, there are not enough CRNAs to fulfill the demand. Our News Bulletin tends to be chock full of advertisements for vacant positions. Quite simply if the rest of the economy was similar to the employment situation for CRNAs, our nation would be at full employment.

Hardly a day goes by for most anesthesia practices when a CRNA is not called by an employment recruiter attempting to entice them into seeking additional pay at another group or hospital. Practices are offering bonuses, attractive benefits, and higher pay in order to recruit CRNAs.

We graduate approximately 1,000 students per year and it is not enough to fill the demand. Our Foundation has recently funded a manpower shortage study and its results are expected shortly.

*How are CRNAs different from anesthesiologists?*

The most substantial difference between CRNAs and anesthesiologists is that prior to anesthesia education, anesthesiologists receive medical education while CRNAs receive a nursing education. However, the anesthesia part of the education is very similar for both providers, and both professionals are educated to perform the same clinical anesthesia services. CRNAs and anesthesiologists are both educated to use the same anesthesia processes and techniques in the provision of anes-

thesia and related services. The practice of anesthesia is a recognized specialty within both the nursing and medical professions. Both CRNAs and anesthesiologists administer anesthesia for all types of surgical procedures, from the simplest to the most complex, either as single providers or in a "care team setting".

*What is our experience on malpractice insurance?*

For the past several years, CRNAs have relied largely on two main major malpractice carriers—St. Paul and TIG. On December 12, 2001, AANA Insurance Services—a wholly owned subsidiary of the AANA—was notified by the St. Paul Companies that it would exit this market and would seek to sell their malpractice book and eventually transition out of the medical malpractice market. We were advised that this difficult decision was based upon "its anticipated worst annual loss in its 148-year old history." The St. Paul further stated that the decision is part of an overall plan "that will put St. Paul on sound financial footing so that they can continue serving their thousands of customers in their other businesses." Their news release goes into more detail concerning losses relative to its losses in malpractice, other insurance lines and those associated with the September 11 terrorist attack.

AANA Insurance Services worked to prepare and assist its policyholders in this transition period and kept them informed of developments relative to their continuing insurance coverage.

The AANA and AANA Insurance Services Staff prepared strategies to respond to this situation proactively to assure a smooth transition for our members insured through St. Paul. We contacted our other carrier at the time, TIG Insurance, to seek support from them and assessed other potential medical malpractice carriers to assure that our members have more than one choice for professional liability insurance as we have in the past.

While we were aware that St Paul Companies were experiencing difficulties along with the rest of the insurance industry, we—along with many other providers and perhaps the general public—were surprised by the sudden decision to withdraw completely from the medical malpractice market. St Paul stated that they would do everything possible to make the transition smooth. We had an excellent relationship with the St. Paul and this transition continues.

Following this announcement, we worked even closer with TIG Insurance Company to ensure a smooth transition for the policyholders of AANA Insurance Services. A few months ago, TIG Insurance Company announced it would no longer be providing medical malpractice insurance. Coverage for CRNAs through TIG will not be available after June 30, 2003. TIG's announcement comes almost exactly a year after St. Paul's announcement that it was withdrawing from the medical malpractice marketplace.

On Monday, December 16, 2002, Fairfax Financial Holdings Limited announced that it would be restructuring TIG. Fairfax, the parent company of TIG, is a financial services holding company which, through its subsidiaries, is engaged in property, casualty and life insurance, reinsurance, investment management and insurance claims management.

As part of the restructuring, TIG indicated that it will be discontinuing its program business. Program business, a specialty of TIG's that represents a majority of its business, is defined as insuring large groups of insured with very similar characteristics. According to Fairfax, TIG's program business was not meeting Fairfax's financial expectations. Unfortunately, all of TIG's medical malpractice business, including the coverage it provides to CRNAs, falls into this program business category.

It should be noted that medical malpractice only accounted for 25% of TIG's program business and TIG's CRNA program was only a small part of the medical malpractice business. Fairfax representatives have informed AANA that the decision to restructure TIG was based neither on the performance of its medical malpractice business in general or its CRNA business in particular.

It is no secret that the number of insurance companies willing to offer medical malpractice coverage has shrunk dramatically over the past few years. Although it's of little consolation, there are many classes of healthcare providers who are facing even greater insurance challenges than CRNAs. While TIG's decision is disappointing, it is not surprising considering the current medical malpractice environment.

Unlike when St. Paul exited from the medical malpractice marketplace, TIG's withdrawal won't be as immediate. TIG will continue to offer both new and renewal policies to AANA members through June 30, 2003. After June 30, 2003, TIG will not provide coverage to new applicants.

Currently AANA Insurance Services provides coverage for members through CNA Insurance Company. It is our understanding that CNA has been approved to do

business in 43 states and the District of Columbia. CNA is awaiting approval in the states of Alaska, Nebraska, Nevada, New Hampshire, New York, Vermont and Washington. AANA Insurance Services expects CNA to have approval in all these states by June 30, 2003.

Obviously this has become extremely troubling to our members. While we have an excellent relationship with CNA Insurance Company, CRNAs are increasing concerned that with only one major medical malpractice carrier remaining, issues of coverage could become problematic. It should be noted that unless a CRNA had a particular issue with claims or licensure, coverage could easily be found, whether it was with St. Paul or TIG. That remains relatively true today with the CNA Insurance Company. But with more carriers leaving the marketplace, what does that do to providers? More importantly, what does it mean to patients and consumers? How do we attract more carriers to this market? Without major reforms, will carriers have any reason to go into the market?

*Patient Safety*

Given the strong safety record of CRNAs, we had no reason to believe then, nor do we now, that there was any nexus between the decision of either St. Paul or TIG to exit the medical malpractice market due to bad claims from CRNAs.

America's CRNAs are committed to advancing patient safety so that actual instances of malpractice are reduced. These commitments including active membership in the cross-disciplinary National Quality Forum (NQF) and the National Patient Safety Foundation (NPSF), closed-claims research that transforms tough cases into educational and practice improvements, and the most stringent continuing education and recertification requirements in the field of anesthesia care. *With CRNAs providing two-thirds of all U.S. anesthetics, the Institute of Medicine reported in 1999 that anesthesia is 50 times safer today than 20 years ago.*

*Our Dilemma*

Educational programs that prepare nurse anesthetists rely solely on hospitals, surgery centers and even office based surgical practices to provide students with the required clinical experiences to enable them to become competent anesthesia providers. These healthcare facilities rely on surgeons and other high-risk specialties for their patient admissions. As these high-risk specialties leave, operating rooms close and patients have less access to needed care, and students have less access to patients for clinical training.

Looking at Pennsylvania as an example, the hospitals and surgeons who are part of a healthcare system located in Southeast Pennsylvania have seen their primary premiums increase more than 60%, their CAT fund increase more than 30%, and their excess premiums increase more than 600%, all within the last year.

The Medical Professional Liability Catastrophe Loss Fund (commonly referred to as the CAT Fund) was established to ensure that victims of medical malpractice are compensated and that medical malpractice insurance is available to health care providers. Health care providers (physicians, surgeons, podiatrists, hospitals and nursing homes) are required to carry a set minimum amount of primary coverage. The health care providers then must pay a surcharge to the CAT Fund in order to fund a layer of insurance above the primary insurance coverage. Failure to comply with this requirement may result in revocation of one's license.

This is reflective of what other healthcare systems in Pennsylvania are experiencing. In addition that system has seen its high-risk specialty physicians relocate out of Pennsylvania or give up the surgical part of their practice. Each time a physician closes his/her office or reduces practice, employees of their practice lose their job. Fewer high-risk specialists mean fewer cases requiring anesthesia are performed. These are exactly the specialties that nurse anesthesia educational programs rely on to provide their students with the required clinical cases.

As surgeons leave the state or reduce surgery because they can not afford the malpractice insurance there are fewer surgical cases, operating rooms are closed, daily operating room schedules are prolonged, overtime costs increase, hospitals' earn less money, layoffs occur and hospitals close. This directly affects patients' access to needed and timely care, and the ability of our educational programs to provide the necessary clinical experiences to educate nurse anesthetists. If this trend continues unabated, nurse anesthesia educational programs (and other healthcare educational programs) will face accreditation issues, declines in student enrollment and delays in graduation as they struggle to find enough clinical experiences for their students. All of this occurring during a time when there is a critical shortage of anesthesia providers nationwide to provide care to an older and sicker population.

The medical malpractice crisis affects all levels of society. Unlimited individual awards for pain and suffering will severely limit the availability and access to care

for the majority. The value we place on timely and complete access to care for all our citizens is reflected in our allowance of an individual's unlimited right to take precedence over the needs of all our people. To insure a healthy society, we must insure access to health care even if it means we place limits on a single category of damages to the individual.

If carriers continue to leave the market and if there should be in difficulty obtaining coverage, it could ultimately mean a slow down for hospitals in providing surgeries. In addition, when CRNAs are employed by hospitals or group practices, these entities have to pick up the tab. If increasing rates continue to become an issue, hospitals will increasingly have to make difficult choices. In those rural hospitals where CRNAs are the sole anesthesia provider, hospitals have no choice if they wish to keep their doors open.

That is why the AANA supports medical liability reform. Many can point an accusatory finger as to why carriers exit the market. However, it makes no sense for an insurer to remain in a market if it cannot do so profitably. High costs and runaway juries and large malpractice awards have become unrealistic and disproportionately high. This is not to say that providers, be they nurses or physicians, should not be held responsible for their actions. All providers must take responsibility. And those providers who may be disproportionately responsible for rate hikes because they have had more than one claim must increasingly take responsibility for their actions as do the nursing and medical boards regulating providers. But by the same token, awards have become too high and many insurers have decided that with the unpredictability of determining how to insure a risk that is seems to be increasingly incalculable, they simply exit the market.

In the 108th Congress, the AANA is pleased to support Rep. Jim Greenwood's (R-PA) legislation, H.R. 5. The HEALTH Act would permit individuals to recover unlimited economic damages and allow for non-economic damages or "pain and suffering" up to $250,000. The states would have the flexibility to establish or maintain their own laws on damage awards. Other provisions in the HEALTH Act address the percentage of damage awards and settlements that go to injured patients as well as allocate damage awards fairly and in proportion to a party's degree of fault and works to decrease the time it takes for a case to settle or go to trial.

Ultimately, it will be incumbent upon insurers, providers, and yes the trial lawyers to work together to find a common solution that works for consumers and patients.

Again, thank you for the opportunity in allowing us to share our views on medical liability reform with the members of this committee.

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## PREPARED STATEMENT OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

On behalf of the American College of Obstetricians and Gynecologists (ACOG), an organization representing more than 45,000 physicians dedicated to improving the health care of women, we urge you to bring an end to the limitless litigation restricting women's access to health care.

ACOG resoundingly supports HR 5, the bipartisan HEALTH Act of 2003, and we urge this Committee, and the House of Representatives as a whole body, to pass this meaningful medical liability reform legislation, which protects women's access to health care.

Across the country, the meteoric rise in medical liability premiums is threatening women's access to health care. Faced with the unaffordability and unavailability of insurance coverage, ob-gyns are forced to stop delivering babies, reduce the number of deliveries, scale back their practices by eliminating high-risk procedures, or close their doors entirely.

This statement will also highlight how the medical liability crisis is acutely affecting a growing number of states, explaining how access to basic and important women's health care in those states is severely jeopardized because of a liability system gone awry.

### I. MEDICAL LIABILITY REFORM: SAFEGUARDING PATIENTS' ACCESS TO CARE

The common sense provisions of the HEALTH Act safeguard patients' access to health care and address the health care crisis:

*PROMOTES SPEEDY RESOLUTION OF CLAIMS*

The Act balances the needs of all parties involved in litigation and promotes a fair result. Health care lawsuits can be filed no later than 3 years after the date of injury. Additionally, the bill acknowledges that in some circumstances, it is im-

portant to guarantee patients additional time to file a claim. Accordingly, the Act extends the statute of limitations for minors injured before age 6.

*FAIRLY ALLOCATES RESPONSIBILITY*

Under the current system, defendants who are only 1% at fault may be held liable for 100% of the damages. This bill eliminates the incentive for plaintiffs' attorneys to search for "deep pockets" and pursue lawsuits against those minimally liable or not liable at all.

*COMPENSATES PATIENT INJURY*

HR 5 ensures injured patients are compensated. The Act does not limit the amount a patient can receive for physical injuries resulting from a provider's care, unless otherwise restricted by state law. The Act only limits unquantifiable non-economic damages, such as pain and suffering, to no more than $250,000.

*MAXIMIZES PATIENT RECOVERY*

Patients will receive the money needed for their health care. HR 5 discourages baseless lawsuits by limiting the incentive to pursue merit-less claims. Without this provision, attorneys could continue to routinely pocket large percentages of an injured patient's award.

*PUTS REASONABLE LIMITS, NOT CAPS, ON THE AWARD OF PUNITIVE DAMAGES*

The Act provides for reasonable punishment without unnecessarily jeopardizing a defendant's fundamental constitutional rights or risking the defendant's bankruptcy. It does not cap punitive damages, rather, it delineates a guideline, allowing for punitive damages to be the greater of two times the amount of economic damages awarded or $250,000.

*ENSURES PAYMENT OF MEDICAL EXPENSES*

HR 5 ensures that injured patients will receive all of the damages to which they are entitled in a timely fashion without risking the bankruptcy of the defendant. Past and current expenses will continue to be paid at the time of judgment or settlement while future damages can be funded over time through the purchase of an annuity or other instrument of secured payment.

*ALLOWS STATE FLEXIBILITY*

The HEALTH Act establishes a ceiling on non-economic damages, and guidelines for the award of punitive damages, only in those states where the state legislature has failed to act. A state legislature may also act at any time in the future to impose a cap the limits of which differ from those provided for in the HEALTH Act.

II. HOW THIS CRISIS COMPROMISES THE DELIVERY OF OBSTETRIC CARE

Obstetrics-gynecology is among the top three specialties in the cost of professional liability insurance premiums. Nationally, insurance premiums for ob-gyns have increased dramatically: the median premium increased 167% between 1982 and 1998. The median rate rose 7% in 2000, 12.5% in 2001, and 15.3% in 2002 with increases as high as 69%, according to a survey by *Medical Liability Monitor*, a newsletter covering the liability insurance industry.

A number of insurers are abandoning coverage of doctors altogether. The St. Paul Companies, Inc., which handled 10% of the physician liability market, withdrew from that market last year. One insurance ratings firm reported that five medical liability insurers failed in 2001. One-fourth of the remaining insurers were rated D+ or lower, an indicator of serious financial problems.

According to Physicians Insurance Association of America, ob-gyns were first among 28 specialty groups in the number of claims filed against them in 2000. Ob-gyns were the highest of all specialty groups in the average cost of defending against a claim in 2000, at a cost of $34,308. In the 1990s, they were first—along with family physicians-general practitioners—in the percentage of claims against them closed with a payout (36%). They were second, after neurologists, in the average claim payment made during that period ($235,059).

Although the number of claims filed against all physicians climbed in recent decades, the phenomenon does not reflect an increased rate of medical negligence. In fact, ob-gyns win most of the claims filed against them. A 1999 ACOG survey of our membership found that over one-half (53.9%) of claims against ob-gyns were dropped by plaintiff's attorneys, dismissed or settled without a payment. Of cases that did proceed, ob-gyns won more than 65% of the cases resolved by court verdict, arbitration, or mediation, meaning only 10% of all cases filed against ob-gyns were found in favor of the plaintiff. Enormous resources are spent to deal with these

claims, only 10% of which are found to have merit. The costs to defend these claims can be staggering and often mean that physicians invest less in new technologies that help patients.

When a jury does grant an award, it can be exorbitant, particularly in states with no upper limit on awards. Jury awards in all civil cases averaged $3.49 million in 1999, up 79% from 1993 awards, according to Jury Verdict Research of Horsham, Pennsylvania. The median medical liability award jumped 43% in one year, from $700,000 in 1999, to $1 million in 2000: it has doubled since 1995.

Ob-gyns are particularly vulnerable to this trend, because of jury awards in birth-related cases involving poor medical outcomes. The average jury award in cases of neurologically impaired infants, which account for 30% of the claims against obstetricians, is nearly $1 million, but can soar much higher. One recent award in a Philadelphia case reached $100 million.

We survey our members regularly on the issue of medical professional liability. According to our most recent survey, the typical ob-gyn is 47 years old, has been in practice for over 15 years—and can expect to be sued 2.53 times over his or her career. Over one-fourth (27.8%) of ACOG Fellows have even been sued for care provided during their residency. In 1999, 76.5% of ACOG Fellows reported they had been sued at least once so far in their career. The average claim takes over four years to resolve.

This high rate of suits does not equate malpractice. Rather, it demonstrates a lawsuit culture where doctors are held responsible for less than perfect outcome. And in obstetrics gynecology, there is no guarantee of a perfect outcome, no matter how perfect the prenatal care and delivery.

### III. WOMEN'S HEALTH CONSEQUENCES OF LIMITLESS LITIGATION

The medical liability crisis is complex, affecting every aspect of our nation's ability to deliver health care services. As partners in women's health care, we urge Congress to end the medical liability insurance crisis. Without legislative intervention, women's access to health care will continue to suffer. Bring an end to the meteoric rise in liability premiums that is already impeding women's access to health care.

This crisis is obstructing mothers' access to obstetric care. When confronted with substantially higher costs for liability coverage, ob-gyns and other women's health care professionals stop delivering babies, reduce the number they do deliver, and further cut back—or eliminate—care for high-risk mothers. With fewer women's health care professionals, access to early prenatal care will also be reduced, depriving them of the proven benefits of early intervention.

Limitless litigation also threatens women's access to gynecologic care. Ob-gyns have, until recently, routinely met women's general health care needs—including regular screenings for gynecologic cancers, hypertension, high cholesterol, diabetes, osteoporosis, sexually transmitted diseases, and other serious health problems. Staggering premiums continue to burden women's health care professionals and will further diminish the availability of women's care.

Legislative intervention is needed to avert another rural health crisis. Women in underserved rural areas have historically been particularly hard hit by the loss of physicians and other women's health care professionals. With the economic viability of delivering babies already marginal due to sparse population and low insurance reimbursement for pregnancy services, increases in liability insurance costs are forcing rural providers to stop delivering babies. Help sustain those providers dedicated to caring for America's rural women and mothers.

Allowing the crisis to continue will mean community clinic cutbacks. Also hurt by the medical liability crisis are the nation's 39 million uninsured patients—the majority of them women and children—who rely on community clinics for health care. Unable to shift higher insurance costs to their patients, these clinics have no alternative but to care for fewer people.

Acting now can save more women from the ranks of the uninsured. Health care costs continue to increase overall, including the cost of private health care coverage. As costs continue to escalate, employers will be discouraged from offering benefits. Many women who would lose their coverage, including a large number of single working mothers, would not be eligible for Medicaid or SCHIP because their incomes are above the eligibility levels. Last year, 11.7 million women of childbearing age were uninsured. Without reform, even more women ages 19 to 44 will move into the ranks of the uninsured.

As ob-gyns, our primary concern is ensuring women access to affordable, quality health care. It is critical that we maintain the highest standard of care for America's women and mothers.

IV. CONCLUSION

Thank you, Mr. Chairman, for your leadership on this important issue and for the Subcommittee's attention to this crisis. ACOG appreciates the opportunity to present our concerns for the panel's consideration and again urges the passage of HR 5, the HEALTH Act of 2003. The College looks forward to working with you as we push for a solution.

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**Legislative Hearing on**

**H.R. 5, The Help Efficient, Accessible, Low-Cost,**

**Timely Healthcare (HEALTH) Act of 2003**

**Tuesday, March 4, 2003**

**2141 Rayburn House Office Building**

**Statement of Mr. John McCormack of Pembroke, Massachusetts**

As a grieving father, I would like to thank you for giving me this opportunity to speak on behalf of my daughter Taylor, and for those who have been victimized due to medical errors that had grave consequences.

The needless death of my 13-month old little girl has taken an emotionally and physically devastating toll on my family -- which will be felt the rest of our lives. A child is not supposed to succumb to death before a parent, unless it is God's will. In the case of my daughter, it was not God's will, it was inept and careless medical care, in which my daughter's condition was not given top priority even though she was in an emergent state.

My wife and I have lost our daughter; my two young boys, Jack and Steven, have lost their sister -- and her death was a needless and preventable.

When our 13 month-old daughter was brought into the emergency room, we were told that the shunt, which was placed in her head at birth, was in failure. Her condition was emergent, and she required immediate surgery. We were then told that since the operation room was too busy, and due to the late hour on a weekend, she was being bumped from surgery that evening, and would have to wait until the next morning. She did not make it until the morning.

Given Taylor's clinical presentations at the time, it was grossly negligent not to have done the surgery immediately. To further compound the problem, she was not even placed in an intensive care unit, nor was she properly monitored while awaiting surgery.

My daughter was showing all the signs of fatal intracranial pressure, which was totally ignored by the nursing staff and the attending resident neurosurgeon -- who failed to even check on my daughter after she was placed in a room.

Prior to being placed in her room, the resident neurosurgeon paged the attending neurosurgeon who was on call that evening, and was suppose to do the surgery. However, he put his pager on vibrate and went to sleep. He never came in, and failed to answer numerous pages. The attending neurosurgeon had given an order to the attending resident neurosurgeon to tap the shunt, which the resident neurosurgeon did do, but the shunt was dry and no fluid was obtained, which was a dangerous condition.

After tapping the shunt the resident neurosurgeon repeatedly paged the attending neurosurgeon to let him know that the shunt could not be tapped, but the attending neurosurgeon had gone to the supermarket to do his shopping, put his pager on vibrate, and, as previously noted, went home and fell asleep. He never answered any of the pages from the resident neurosurgeon, and never bothered to inquire as to the results of the shunt tap or my daughter's condition.

My wife was with our daughter the entire time. The last word our daughter ever spoke was "Mama" at 2:00am. To me, she was crying out for help, a nurse gave her Tylenol and said that it was just irritability.

The resident neurosurgeon who rendered care to my daughter that evening has a limited medical license that has expired, yet he was left in charge to call the shots. He has order blood tests, which were taken that evening and showed that my daughter had critical carbon dioxide levels, as well as abnormal potassium and sodium levels. But nobody, including the resident neurosurgeon, even bothered to inquire, acknowledge, or address these abnormal tests.

Although Intensive Care Unit monitoring was needed, my daughter was not placed ICU. No doctor even examined my daughter from the time she was admitted at 12:20am to the time she went into respiratory arrest at 6:20am

The hospital could have done a bedside procedure to relieve the pressure on my daughter's brain, but did not even given her Manitol to reduce the brain swelling.

While my wife was being interviewed by the anesthesiologist, the heart monitor was going off. My wife asked if our daughter was alright, he looked at the monitor and the chart, but never looked at our daughter. He replied that our daughter had a slow heart rate during the night, and that she will be all right. My wife got up to look at our child and she was blue. The nurse came in and told the anesthesiologist to press the red button, which is the code button. He replied what red button.

A child's death causes permanent, life long pain and suffering for the family of that child -- especially when the death could and should have been prevented.

There are many fine doctors and nurses throughout the medical institutions in the United States. But doctors and nurses must also be held accountable and responsible when egregious decisions result in death, and leave families emotionally devastated.

Medical errors cause up to 98,000 deaths per year, more than breast cancer, AIDS and motor vehicle related deaths. 1 out of 3 doctors witness medical errors everyday. Five percent pf physicians in the United States cause 54 percent of malpractice.

A cap on medical malpractice lawsuits, could result in doctors and nurses feeling immune to decisions they make -- decisions that could result in a lifetime of physical and emotional pain and suffering for patients, and their loved ones. Bad doctors need to be held accountable.

A topic this serious should be part of a national debate, where every opinion and voice shall be heard.

The solution to this problem is insurance reform. Force the medical insurance industry to open its books. The reason that they are losing money is the economy and the mismanagement of funds, not malpractice jury awards. Stop price gouging the system, take responsibility and clean up you own house.

Finally, I come before you today as a parent, and on behalf of all the victims and survivors, to respectfully request a meeting with President Bush, Majority Leader Frist, the AMA, and medical insurance companies, who repeatedly call our pain and suffering frivolous. We want to make sure they hear our side. Please be open to the opportunity to hear the voices of the victims and their loved ones.

John McCormack
Pembroke, Massachusetts
*www.memorial2taylor.com*

MATERIAL SUBMITTED FOR THE HEARING RECORD

# Addressing the New Health Care Crisis:

## Reforming the Medical Litigation System to Improve the Quality of Health Care

March 3, 2003

Prepared by
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of the Assistant Secretary for Planning and Evaluation

# TABLE OF CONTENTS

# ADDRESSING THE NEW HEALTH CARE CRISIS:
## Reforming the Medical Litigation System to Improve the Quality of Health Care

### Introduction

Americans enjoy high quality health care. But we can do better. To that end, the Administration is undertaking a number of initiatives to increase access to care, while enhancing even further the quality of care and constraining cost increases. The Administration is acting to make more information available to consumers to help them identify quality care and to choose providers that offer quality care. We are encouraging and promoting the introduction of computer technology in health care to support the efforts of health professionals and to reduce the chance of error. Reform of the litigation system is a further, critical part of our efforts to improve quality. The excesses of the litigation system raise the cost of health care for everyone, threaten Americans' access to care, and impede efforts to improve the quality of care.

Americans spend far more per person on the costs of litigation than any other country in the world. The excesses of the litigation system are an important contributor to "defensive medicine"--medical treatments provided for the purpose of avoiding litigation. Doctors' insurance premiums are increasing at a rapid rate, particularly in states that have not taken steps to make their legal systems function more predictably and effectively. Some doctors cannot obtain insurance despite having never had a single malpractice judgment or even faced a claim. As multimillion-dollar jury awards have become more common in recent years, these problems have reached crisis proportions.

This is a threat to health care quality for all Americans. Increasingly, Americans are at risk of not being able to find a doctor when they most need one. Doctors have given up their practices, limited their practices to patients who do not have health conditions that are more likely to lead to lawsuits, or have moved to states with a fairer legal system where insurance can be obtained at a lower price. In addition, excessive litigation is impeding efforts to improve quality of care. Hospitals, doctors, and nurses are reluctant to report problems and participate in joint efforts to improve care because they fear being dragged into lawsuits, even if they did nothing wrong.

This broken system of litigation also is raising the cost of health care that all Americans pay, through out-of-pocket payments, insurance premiums, and taxes.

Judgments for very large amounts of non-economic damages in a small proportion of cases and the settlements they influence are driving this litigation crisis. At the same time, most injured patients receive no compensation. The

current litigation system hurts everyone--injured patients and Americans seeking high-quality care. The only ones who benefit are those who operate the system--particularly the trial lawyers who bring these cases and those who defend them. Some states have already taken action to squeeze the excesses out of the litigation system. But federal action, in conjunction with further action by states, is essential to help Americans get high-quality care when they need it, at a more affordable cost.

We reported on the growing access crisis in the report we issued on July 24, 2002,[1] and updated with two supplements.[2] As we predicted, the crisis has only worsened since we issued those reports. The scope and intensity of the crisis have increased. More doctors, hospitals, and nursing homes in more states are facing increasing difficulty in obtaining insurance against lawsuits, and as a result more patients in more states are facing greater difficulty in obtaining access to doctors. Premiums charged to specialists in 18 states without reasonable limits on non-economic damages increased by 39% between 2000 and 2001.[3] Premiums in these states have now gone up an additional 51%.[4] Thus, specialty premiums have almost doubled in two years in hard-hit states. This report describes the problems we currently face, the reasons these problems have arisen, and how we can fix them.

# I. THE CRISIS AFFECTS ALL AMERICANS

## 1. Access to Care is Threatened

There are a number of obstacles that limit access to affordable health care in this country, including the difficulty many Americans have in obtaining private insurance and an outdated Medicare program. We now face another obstacle--the litigation crisis that has made insurance premiums unaffordable or even unavailable for many doctors, through no fault of their own. This is currently making it more difficult for many Americans to find care, and threatening access for many more. This crisis affects patients, physicians, hospitals, and nursing homes all across the United States.

The crisis is affecting access to care in numerous ways in states that have not reformed their litigation systems. A few examples of the real problems we face:

- Three obstetrician-gynecologists who staffed a practice responsible for delivering half of all babies in Fayette County, Pennsylvania, stopped delivering babies effective November 1 in an effort to reduce malpractice premium expense. The policy would have been $400,000 if they had continued OB services and will be under $100,000 without it.[5]

- Dr. Lauren Plante, a maternal-fetal medicine specialist in Philadelphia, stopped practicing because her malpractice insurance premiums increased 60% in one year.[6]

- Dr. Peter Blanc, a vascular surgeon in Wilkes-Barre, shut down his practice in August because "...increasing insurance premiums have forced him out of business." Dr. Blanc, who has never been sued, would have had to pay $51,000 to renew his medical liability coverage in October, up from $27,000 in 2000.[7]

- Abington (PA) Memorial Hospital closed the only trauma center in Montgomery County at the end of 2002 because insurance carriers were not willing to offer malpractice liability insurance to doctors staffing it. Since 1999, annual hospital liability premiums have risen from $7 million to $23 million.[8]

- In Tacoma, Washington, some doctors were faced with a tripling of their premiums. The Washington State Medical Association has reported a 31% increase in the number of physician members moving out of state since 1998.[9]

- The Vermont Medical Society reported that malpractice premiums are rising so rapidly that doctors are being forced out of the profession.[10]

- According to the president of the Massachusetts Medical Society, obstetricians in the state have seen their insurance premiums double in the past year. Insurance premiums for obstetrician-gynecologists in Massachusetts are among the highest in the country and have forced several doctors practicing in the Springfield area to stop delivering babies.[11]

- The University of Nevada School of Medicine has estimated that Clark County should have between 150 and 160 obstetricians delivering babies but has only 85 in practice, due to the medical litigation crisis.[12]

- The University of Nevada Medical Center closed its trauma center in Las Vegas for ten days in July 2002. Its surgeons had quit because they could no longer afford malpractice insurance.[13] Their premiums had increased sharply, some from $40,000 to $200,000. The trauma center was able to re-open only because some of the surgeons agreed to become county government employees for a limited time, which capped their liability for non-economic damages if they were sued. This is obviously only a temporary solution.

- Dr. Cheryl Edwards, 41, closed her decade-old obstetrics and gynecology practice in Las Vegas because her insurance premium jumped from $37,000 to $150,000 a year. She moved her practice to West Los Angeles, leaving 30 pregnant women to find new doctors.[14]

- Dr. Darren Housel, who had been practicing in Las Vegas since 1996 delivering more than 200 babies a year, saw his patients for the last time September 19. He moved to Utah, where his malpractice premiums will drop from nearly $100,000 to $39,000 annually.[15]

- Dr. Frank Jordan, a vascular surgeon, in Las Vegas, closed his practice. "I did the math. If I were to stay in business for three years, it would cost me $1.2 million for insurance. I obviously can't afford that. I'd be bankrupt after the first year, and I'd just be working for the insurance company. What's the point?"[16]

- A doctor in a small town in North Carolina decided to take early retirement when his premiums skyrocketed from $7,500 to $37,000 per year. His partner, unable to afford the practice expenses by himself, may now close the practice, and work at a teaching hospital.[17]

- Many physicians in Ohio saw their malpractice premiums triple in 2001, and some are leaving their practice as a result. Dr. James Wilkerson, an Akron urologist, decided to retire. Had Dr. Wilkerson continued to practice, he would have spent seven months of his yearly income to cover the $84,000

premium. "I would have had to go back to working 90 hours a week and I didn't want to do that..."[18]

- West Virginia is also facing critical access problems for urgently needed care such as obstetrics. In rural areas, such as Putnam County and Jackson County, the sole community provider hospitals have closed their OB units because the obstetricians in those areas cannot afford malpractice insurance.[19]

- Many communities in Mississippi are losing access to needed medical care. Physicians, who specialize in family medicine and obstetrics/gynecology in Indianola, and in other rural areas of the state, have stopped delivering babies because of skyrocketing insurance costs.[20]

- Most of the cities with populations under 20,000 in Mississippi no longer have doctors who deliver babies.[21]

- Due to rising insurance costs, only one doctor with expertise in head trauma was available last July to cover all the hospitals in Gulfport, Mississippi. Tony Dyess suffered permanent brain damage as a result.[22]

- One in six participants in an August 2002 survey by the Florida Medical Directors Association reported that attending physicians have stopped following patients in nursing homes in the last 12 months because of difficulty obtaining liability coverage; 27% reported that physicians in their facilities had been informed that their medical liability coverage would not be renewed or would be more costly because they attended patients in nursing homes. In 2001, Florida had one of the highest premium costs per nursing home bed in the United States ($11,000).[23]

- In Georgia, the 80-bed Bacon County Hospital in Alma took out a loan to cover a premium that more than tripled.[24]

- Another Georgia hospital, Memorial Hospital and Manor in Bainbridge, which operates a hospital and a nursing home, was faced with a 600% premium increase from 2001 to 2002.[25]

- In New Jersey, 65% of the hospitals report that physicians are leaving because of increased premiums (over 250% over the last three years).[26]

- Arizona Family Care Association, an operator of rural health clinics on the Arizona-Mexico border, saw its malpractice insurance increase from $500,000 per year with no deductible to $897,000 per year with a $50,000 deductible, and that was only if it stopped performing OB. AFCA stopped delivering babies; the closest OB services are an hour away.[27]

- The Wyoming Medical Society has indicated that it is increasingly difficult for physicians to stay in business due to increasing medical liability costs--one of the two insurance carriers providing OB coverage increased rates 40% in 2002.[28] Dr. Willard Wood, an obstetrician serving three Wyoming counties, stopped delivering babies during the winter of 2003; his annual malpractice premium to provide only gynecological services was $116,000, or three times what he had paid a year earlier.[29]

- Doctors who would volunteer their time to provide care in free clinics and other volunteer organizations, or who would volunteer their services to the Medical Reserve Corps, are afraid to do so because they do not have malpractice insurance. This makes it more difficult for clinics to provide care to low-income patients. The clinics must spend their precious resources to obtain their own coverage, and have less money available to provide care to people who need it. The proportion of physicians in the country providing any charity care fell from 76% to 72% between 1997 and 1999 alone, increasing the need for doctors willing to volunteer their services.[30] Health Link Medical Center opened in March 2001 in Southampton, Pennsylvania, to provide free health care to the working poor. Dr. Theodore Onifer, a retired physician, volunteered his services on the board but was unable to volunteer to provide medical care because of the fear of lawsuits and the cost of insurance.

- A substantial number of nursing home chains, including Beverly Enterprises, National Healthcare Corporation, Extendicare and Health Ventures, have been forced to sell nursing homes in Florida and Arkansas because they could not obtain liability insurance coverage for these facilities.[31]

- Six of the largest nursing home companies, both privately and publicly owned, have filed for bankruptcy in the past two years. A significant factor in their financial downturn is uncontrolled costs associated with medical liability premiums and tort related expenses.[32]

The American Medical Association has reported that an alarming number of physicians are unable to obtain or afford medical liability insurance in 12 states.[33] The American College of Obstetricians and Gynecologists (ACOG) has identified nine states in which access to care is compromised due to availability and affordability of malpractice insurance for obstetricians.[34] A 2002 ACOG survey of obstetrician-gynecologists found that 73% of respondents in these states have been forced to retire, relocate, or modify their practice (e.g. decrease surgical procedures, stop obstetrics, and/or decrease the amount of high-risk obstetric care).[35]

Similarly, the American Association of Neurological Surgeons has identified 25 crisis states in which neurosurgeons faced either a 50 percent increase in premiums from 2000 to 2002, or average premiums near or over $100,000 in 2002.[36]

A new study conducted by the American Hospital Association and the American Society of Hospital Risk Management demonstrates that the scope of the crisis extends beyond physicians: one-third of hospitals saw an increase of 100% or more in liability insurance premiums in 2002. Over one-fourth reported either a curtailment or complete discontinuation of one service or another as a result of growing liability premium expenses.[37]

The effect this crisis is having on patients' access to care is indicated by a recent survey conducted by the Blue Cross Blue Shield Association (BCBS).[38] A substantial number of BCBS plans predict that surgical fees and emergency room costs will increase as a result of higher medical malpractice premiums.

## 2. Quality of Care is Jeopardized

**Physicians Too Often Order Procedures for Litigation Purposes, not Medical Need**

The litigation crisis affects the quality of care available to Americans in a number of ways. Physicians are reacting to the threat of litigation by avoiding the specialties that present the greatest risk of suit. A recent survey of physicians reveals that one-third shied away from going into a particular specialty because they feared it would subject them to greater liability exposure.[39] When in practice, physicians increasingly are forced to engage in defensive medicine to protect themselves against suit. They perform tests and provide treatments that they would not otherwise perform merely to protect themselves against the risk of possible litigation. The recent survey revealed that over 76% of physicians are concerned that malpractice litigation has hurt their ability to provide quality care to patients.[40] Because of their fear of the excesses of the litigation system:

- 79% said that they had ordered more tests than they would, based only on professional judgment of what is medically needed, and 91% have noticed other physicians ordering more tests;
- 74% have referred patients to specialists more often than they believed was medically necessary;
- 51% have recommended invasive procedures such as biopsies to confirm diagnoses more often than they believed was medically necessary; and
- 41% said that they had prescribed more medications, such as antibiotics, than they would based only on their professional judgment, and 73% have noticed other doctors similarly prescribing excessive medications.

A large majority of nurses (66%) and hospital administrators (84%) who participated in the survey reported that unnecessary or excessive care is provided because of fear of litigation.[41] Every test and every treatment that is not

taken for medical reasons poses an unnecessary risk to the patient, and takes away funds that could better be used to provide health care to those who need it.

A recent survey of 1,573 physicians in three South Florida counties[42] revealed how litigation fears have influenced the way physicians practice:

- 44% recently stopped performing high-risk procedures, including some spinal surgeries and treatment of chest wounds;
- 66% are performing more tests to protect themselves from lawsuits;
- One in nine respondents no longer has malpractice coverage;
- Seven of 29 radiologists have stopped reading mammograms; and
- Almost 31% limit their practice in hospital emergency rooms.

**The Litigation System Does Not Promote Quality of Care**

The liability system is not an effective way of improving quality. In many cases it does not provide a useful guide to what care should be, and does not provide a guide to providers or to patients. A comprehensive study of the prevalence of medical errors found that most events for which claims were filed in fact did not constitute negligence.[43] Other studies demonstrate the same pattern of randomness.[44] Several medico-legal scholars have noted that "Evidence is growing that there is a poor correlation between injuries caused by negligent medical treatment and malpractice litigation.... [I]n a sample of 31,000 patients treated in 51 New York State hospitals, there was a poor correlation between a malpractice suit and the presence of actual malpractice."[45]

Not surprisingly, most professionals involved in health care delivery believe that the system does not accurately reflect the realities of health care or correctly identify malpractice. A 2002 survey indicated that 83% of physicians and 72% of hospital administrators do not believe the system achieves a reasonable result.[46]

Because its results are largely random and unpredictable, the litigation system often does not accurately identify negligence, deter bad conduct, or provide justice. "The evidence is growing that there is a poor correlation between injuries caused by negligent medical treatment and malpractice litigation."[47]

For example, obstetricians face more suits than any other specialty, more than two per career on average, and claims for neurologically impaired infants make up 30 percent of them, according to the American College of Obstetricians and Gynecologists. The average award by juries in such cases is about $1 million. However, a study released in January 2003 finds that doctors are often sued for brain damage that can result from oxygen deprivation during delivery, even though the vast majority of such cases actually stem from infections and causes that are beyond the control of physicians and other delivery room staff.[48] The study, which is "one of the most highly peer-reviewed reports ever,"[49] suggests that suits are being brought against doctors for brain damage and cerebral palsy that were not caused by negligent care.[50]

With this randomness, the litigation system cannot be relied upon to deter error or set meaningful standards of care. That this is in fact the case is evidenced by the Institute of Medicine's estimate that as many as 98,000 people die each year from medical error.[51] Results like these indicate that the current system is failing to ensure quality care.

**The Litigation System in Fact Impedes Efforts to Improve the Safety and Quality of Care**

Health professionals' understandable fear of unwarranted litigation threatens patient safety in another way. It impedes efforts of physicians and researchers to improve the quality of care. Specifically, fear of liability discourages open discussion of medical errors and ways to reduce them. As medical care becomes increasingly complex, there are many opportunities for improving the quality and safety of medical care, and reducing its costs. However, because of the litigation environment, only one-fourth of physicians, nurses and hospital administrators think that their colleagues are very comfortable discussing adverse events or uncertainty about proper treatment with them. Even fewer, roughly 5%, think that their colleagues are very comfortable discussing medical errors with them.[52]

The best way to achieve these needed improvements in quality of care is to provide better opportunities for health professionals to work together to identify errors, or practices that may lead to errors, and to correct them. Experts believe these quality improvement opportunities hold the promise not only of significant improvements in patient health outcomes, but also of reductions in medical costs by as much as 30%.[53] Many problems in the health care system result not from one individual's failings, but from complex system failings. These can best be addressed by collecting information from a broad range of doctors and hospitals, and encouraging them to collaborate to identify and fix problems. Already many health care systems are beginning to make these improvements:

- Intermountain Health Care and LDS Hospital in Utah improved quality and efficiency of the intensive care unit by applying quality improvement techniques and improving collaborative efforts.

- The Pittsburgh Regional Healthcare Initiative has brought together hospitals, health plans, physicians, and purchasers of health care in a collaborative effort to identify better ways to provide care. It has reduced blood infections in intensive care units by 20% in just two years, and it is encouraging reporting to reduce medication errors.

- The Baylor Medical Center in Dallas, Texas, has recently initiated an error reporting system and integrated it into care delivery to reduce medication and other errors.[54]

- Through the Northern New England Cardiovascular Disease Study Group, eight hospitals reduced mortality for cardiac bypass surgery by developing a collaborative patient registry, tracking how care is delivered and what the outcomes are, and sharing what they learn.

- A proprietary drug-dispensing system developed by the Veterans' Administration that uses bar-code technology has reduced problems associated with medication errors by 74% in the five years since its introduction.[55]

However, these efforts and other efforts are impeded and discouraged by the lack of clear and comprehensive protection for collaborative quality efforts. Doctors are reluctant to collect quality-related information and work together to act on it for fear that it will be used against them or their colleagues in a lawsuit. Perhaps as many as 95% of adverse events are believed to go unreported.[56] To make quality improvements, doctors must be able to exchange information about patient care and how it can be improved--what is the effect of care not just in one particular institution or of the care provided by one doctor, but how the patient fares across all providers. These quality efforts require enhancements to information and reporting systems.

In its report, "To Err is Human," the Institute of Medicine (IOM) observed that, "[R]eporting systems are an important part of improving patient safety and should be encouraged. These voluntary reporting systems [should] periodically assess whether additional efforts are needed to address gaps in information to improve patient safety and to encourage health care organizations to participate in...reporting, and track the development of new reporting systems as they form."[57]

However, as the IOM emphasized, fear that information from these reporting systems will be used to prepare a lawsuit against them, even if they are not negligent, deters doctors and hospitals from making reports. This fear, which is understandable in the current litigation climate, impedes quality improvement efforts. According to many experts, the "#1 barrier" to more effective quality improvement systems in health care organizations is fear of creating new avenues of liability by conducting earnest analyses of how health care can be improved. Without protection, quality discussions to improve health care can be used as fodder for more litigation. Doctors are busy, and they face many pressures. They will be reluctant to engage in health care improvement efforts if they think that reports they make and recommendations they offer will be thrown back at them or others in litigation. Quality improvement efforts must be protected if we are to obtain the full benefit of doctors' experience in improving the quality of health care.

The IOM Report emphasized the importance of shifting the inquiry from individuals to the systems in which they work: "The focus must shift from blaming individuals for past errors to a focus on preventing future errors by

designing safety into the system."[58] But the litigation system impedes this progress--not only because fear of litigation deters reporting but also because the scope of the litigation system's view is restricted. The litigation system looks at the past, not the future, and focuses on the individual in an effort to assess blame rather than considering how improvements can be made in the system. "Tort law's overly emotional and individualized approach...has been a tragic failure."[59]

## 3. Health Care Costs are Increased

The medical litigation system attacks the wallet of every American. Money spent on malpractice premiums (and the litigation costs that largely determine those premiums) raises health care costs. A GAO study in 1994 estimated that malpractice premiums comprise 1% of total health care expenditures; given current spending, this amounts to $14 billion dollars.[60]

The litigation system also imposes large indirect costs on the health care system. Defensive medicine that is caused by unlimited and unpredictable liability awards not only increases patients' risk but it also adds costs. A leading study estimates that reasonable limits on non-economic damages, such as California has had in effect for 25 years, can reduce health care costs by 5-9% without "substantial effects on mortality or medical complications."[61] With national health care expenditures currently estimated to be $1.4 trillion, if this reform were adopted nationally, it would save $70-126 billion in health care costs per year.

The costs of the runaway litigation system are paid by all Americans, through higher premiums for health insurance (which reduces workers' take home pay if the insurance is provided by an employer), higher out-of-pocket payments when they obtain care, and higher taxes.

The Federal Government--and thus every taxpayer who pays federal income and payroll taxes--pays for health care in a number of ways. It provides direct care, for instance, to members of the armed forces, veterans, and patients served by the Indian Health Service. It provides funding for the Medicare and Medicaid programs. It funds Community Health Centers. It also provides assistance, through the tax system, for workers who obtain insurance through their employment. The Federal Government spends $33.7-$56.2 billion per year for malpractice coverage and the costs of defensive medicine.[62] Reasonable limits on non-economic damages would reduce the amount of taxpayers' money the Federal Government spends by $28.1-$50.6 billion per year.[63]

# II. THE LITIGATION SYSTEM IS RESPONSIBLE FOR THE CRISIS

The crisis that we face--as consumers, taxpayers, or health care professionals--is caused by our expensive litigation system, which often finds liability on a random basis and increasingly imposes very large judgments for non-economic damages.

The insurance premiums that health professionals and hospitals must pay are largely determined by the costs that the litigation system imposes on the insurers. The malpractice insurance system and the litigation system are inexorably linked.

Although most cases do not actually go to trial, it costs a significant amount of money to defend each claim--expenses on claims settled in 2001 averaged $39,819.[64] Data from states that maintain this information demonstrate the rapid rate of increase in recent years. Between 1999 and 2001, the average expense, per defendant, in a medical litigation case in Illinois increased 30.3% (from $14,855 to $19,363).[65] In the period 1980 to 1984, the average defense cost in Missouri was $4,700; in the period 1995 and 1999, it increased to almost $19,000--an increase of more than 300% percent.[66]

And payments made on claims are increasing. In Illinois, the average payment per paid claim increased from just under $129,000 in the period 1980-1984 to almost $500,000 in the period 1995-1999.[67] Missouri reported similar increases--the average payment per defendant rose 38% between 1999 and 2001.[68]

Between 1991 and 2001, the number of payments made for malpractice claims against physicians reported to the National Practitioner Data Bank (NPDB) increased 21.6% from 13,711 to 16,676.[69] During this same period, the median payment more than doubled--from $63,750 to $135,941--while the maximum reported payment escalated from $5,300,000 to $20,700,000.[70]

Of particular concern is the rise in mega-awards and settlements. The number of payments of $1 million or more reported to the NPDB exploded in the past 7 years, not only in AMA crisis states such as New Jersey, Pennsylvania and Ohio, but nationwide. Between 1991 and 2002, the number of payments of $1 million or more that were reported to the NPDB increased from 298 to 806; payments of $1 million or more increased from 2.2% to 5.4% of total payments reported. While the NPDB represents the most comprehensive data source for medical malpractice claims payments, it may understate the extent of the crisis since it includes all doctors, and the problem is concentrated in high risk specialties.

Mega-awards for non-economic damages have occurred in states that do not have limitations on the amounts of non-economic damages that can be recovered. A number of states have experienced mega-judgments. See Table 1.

| TABLE 1. Mega Awards In States Without Caps | | |
|---|---|---|
| **State** | **Jury Award** | **Year** |
| Arizona | $3,000,000 | 1998 |
| Kentucky | $13,000,000 | 1998 |
| Mississippi | $100,000,000 | 2002 |
| Nevada | $6,000,000 | 2001 |
| | $5,400,000 | 2001 |
| | $4,600,000 | 2001 |
| New York | $94,500,000 | 2002 |
| | $80,000,000 | 2002 |
| | $91,000,000 | 2002 |
| North Carolina | $23,500,000 | 1997 |
| | $4,500,000 | 2001 |
| | $8,100,000 | 2001 |
| Ohio | $3,500,000 | 2002 |
| Pennsylvania | $100,000,000 | 1999 |
| | $7,000,000 | 2003 |
| Texas | $4,400,000 | 2002 |
| Washington | $3,790,000 | 1998 |
| Source: ASPE Review of Media Reports from The Advocate, Las Vegas Review, North Carolina Lawyers Weekly, and other select sources. | | |

A large proportion of these awards are not to compensate injured patients for their economic loss--such as wage loss, health care costs, and replacing services the injured patient can longer perform (such as child care). Much of the judgment (in some cases, particularly the largest judgments, perhaps 50% or more) is for non-economic damages. Awarded on top of compensation for the injured patient's actual economic loss, non-economic damages are meant to be compensation for intangible, non-monetary losses, such as pain and suffering, loss of consortium, hedonic (loss of the enjoyment of life) damages, and various other theories that are developed.

Recent data from the Florida Department of Insurance Closed Claims Database show that non-economic damages comprised 77% of awards.[71] In Texas, the average judgment today is $2.1 million; of that, 70% is for non-economic damages. Texas has experienced a 500% increase in the size of judgments awarded in the last 10 years.[72]

Non-economic damages are an effort to compensate a plaintiff with money for what are in reality non-monetary considerations. The theories on which these awards are made however, are entirely subjective. As one scholar has observed: "The perceived problem of pain and suffering awards is not simply the amount of money expended, but also the erratic nature of the process by which the size of the awards is determined. Juries are simply told to apply their 'enlightened conscience' in selecting a monetary figure they consider to be fair."[73]

Unless a state has adopted limitations on non-economic damages, the system essentially gives juries a blank check to award huge damages.

Even though few cases end with mega jury awards, they encourage lawyers in the hope that they can win this litigation lottery, and they influence every settlement that is entered into. Mirroring the increase in jury awards, settlement payments have steadily risen over the last two decades. The average settlement payment per paid claim increased from approximately $110,000 in 1987 to $250,000 in 1999.[74]

# III. THE LITIGATION SYSTEM DOES NOT BENEFIT THE INJURED PATIENT

The litigation system is expensive, and, at the same time, it is slow and provides little benefit to patients who are injured by medical error.

Most victims of medical error do not file a claim--one comprehensive study found that only 1.53% of those who were injured by medical negligence even filed a claim.[75] When a patient does decide to go into the litigation system, only a very small number recover anything. Most claims--57-70%--result in no payment to the patient.[76, 77] One study found that only 8-13% of cases filed went to trial; and only 1.2-1.9% resulted in a decision for the plaintiff.[78]

The results are as arbitrary for patients as they are for providers. When there are recoveries, they often are based on sympathy, attractiveness of the plaintiff, and the plaintiff's socio-economic status (educated, attractive patients recover more than others).[79]

One prominent personal injury trial lawyer explained the secret of his success: "The appearance of the plaintiff [is] number one in attempting to evaluate a lawsuit because I think that a good healthy-appearing type, one who would be likeable and one that the jury is going to want to do something for, can make your case worth double at least for what it would be otherwise and a bad-appearing plaintiff could make the case worth perhaps half..."[80]

Only a small number of claimants achieve the large judgment for non-economic losses. A winning lottery ticket in litigation, moreover, is not as attractive as it may seem at first blush. A plaintiff who wins a judgment must pay the lawyer 30-40% of it, and sometimes even more. Lawyers, therefore, have an interest in finding the most attractive case. They develop a portfolio of cases and have an incentive to gamble on a big "win." If only one case results in a huge verdict, they have had a good payday. Thus, they have incentives to pursue selected cases to the end in the hope of winning the lottery, even when their client would be satisfied by a settlement that would make them whole economically. The result of the contingency fee arrangement is that lawyers have few incentives to take on the more difficult cases or those of less attractive patients.

For most injured patients, therefore, the litigation process, while offering the remote chance of a jackpot judgment, provides little real benefit, even for those who file claims and pursue them. Even successful claimants do not recover anything on average until five years after the injury, longer if the case goes to trial.[81]

The friction generated by operating the system consumes most of the money. When doctors and hospitals buy insurance (sometimes they are required to buy coverage that provides more "protection" than the total amount of their assets), it is intended to compensate victims of malpractice for their loss. However, only 28% of what they pay for insurance coverage actually goes to patients; 72% is spent on legal, administrative, and related costs.[82]

Our current system forces injured patients to sue their doctors in order to obtain compensation and forces both patients and doctors to go through what is a traumatic process for all. Patients must wait years for recovery (if they ever win any). Doctors are subject to minute scrutiny of actions they took, often years before, and their actions are judged on the basis of hindsight and perhaps even on the basis of changed medical standards. The process consumes the time and energy of the doctor that could better be spent in patient care. It is essentially punitive in nature, yet random. Rather than helping doctors do better, it causes them to engage in defensive medicine. It is a process that benefits no one except those who must operate it--trial lawyers, both those who represent plaintiffs and those who represent defendants.

The cost of these awards for non-economic damages is paid by all other Americans through higher health care costs, higher health insurance premiums, higher taxes, reduced access to quality care, and threats to quality of care. The system permits a few plaintiffs and their lawyers to impose what is in effect a tax on the rest of the country to reward a very small number of patients--and their lawyers--who happen to win the litigation lottery. It is not a democratic process.

# IV. AS A RESULT, INSURANCE PREMIUMS ARE RISING RAPIDLY

The costs imposed by the litigation system show up in the cost of insurance coverage. Premiums have increased rapidly over the past several years, particularly for doctors who practice internal medicine, general surgery, and obstetrics/gynecology (see Table 2 below). The average increases ranged from 12% to 18% in 2000, were about 10% in 2001, but accelerated rapidly in 2002. The most recent report revealed that rate increases are now averaging 20% and above.[83]

**TABLE 2. Medical Malpractice Liability Average Premium Increases by Specialty (Date is When Survey Was Taken, Compared to Previous Period)**

| Specialty | July 2000 | July 2001 | July 2002 |
|---|---|---|---|
| Internists | 18% | 10% | 25% |
| General Surgeons | 15% | 10% | 25% |
| Obstetrician/Gynecologists | 12% | 9% | 20% |

Source: Medical Liability Monitor. The data reflect an average for the listed specialties in all states. Averaging disguises the different experiences in states that have reformed their litigation systems and those that have not.

As seen in Table 3, which shows the highest rate increase reported for any of the three specialties, specialty physicians in states without reasonable limits on non-economic damages have experienced very significant premium increases from 2001 to 2002.

| TABLE 3. Highest Premium Increases for Specialists in States without Meaningful Caps* | |
|---|---|
| **State** | **Premium Increase from 2001- 2002** |
| Arkansas | 112% |
| Connecticut | 40% |
| Florida+ | 75% |
| Georgia | 40% |
| Maryland | 37% |
| Mississippi | 99% |
| Nebraska | 36% |
| Nevada | 50% |
| New Hampshire | 50% |
| North Carolina | 50% |
| Ohio+ | 60% |
| Oregon | 80% |
| Pennsylvania | 40% |
| South Carolina | 42% |
| Tennessee | 65% |
| Texas+ | 40% |
| Virginia | 113% |
| Wyoming | 38% |

Source: Medical Liability Monitor, 2002.
*Highest increase in rates for internal medicine, general surgery or obstetrics-gynecology as reported in MLM Survey, October 2002.
+ Florida imposes a cap of $250,000-$350,000 unless neither party demands binding arbitration or the defendant refuses to arbitrate. Florida is not considered to have a meaningful cap on non-economic damages because of the confusion associated with the arbitration provision. An Ohio statute limiting non-economic damages was declared unconstitutional in 1999. The Texas statute limits damages ($1.4 million in 2002) in wrongful death cases only; application of it to all negligence actions was ruled unconstitutional in 1990.

Analyzing the data differently, the same pattern is evident in Table 4, which shows that the highest premium increases averaged among all three specialists increased substantially in 2002.

| TABLE 4. Average Combined Highest Premium Increases for Specialty Providers in States Experiencing a Litigation Crisis | |
|---|---|
| **State** | **Premium Increase from 2001- 2002** |
| Florida | 61% |
| Iowa | 29% |
| Mississippi | 66% |
| Nebraska | 31% |
| New Hampshire | 42% |
| North Carolina | 50% |
| South Carolina | 38% |
| Tennessee | 30% |
| Virginia | 22% |
| Source: Medical Liability Monitor, October 2002. Data represent the average of the highest premiums reported for internal medicine, general surgery and obstetrics-gynecology specialists. | |

The states with the highest average premiums are states that have not reformed their litigation systems.[84] Table 5 compares the premiums in non-reform states with those charged in California, which reformed its system in 1975.

| TABLE 5. States with High Premiums in 2002 by Specialty, Compared to California | | | |
|---|---|---|---|
| **State** | **OB/GYNs** | **Surgeons** | **Internists** |
| Florida | $211-$78K | $164-$55K | $56-$15K |
| Nevada | $142-$59K | $85-$38K | $23-$11K |
| Michigan | $141-$51K | $107-$43K | $46-$14K |
| New York | $115-$33K | $66-$19K | $17-$6K |
| Illinois | $110-$47K | $76-$29K | $32-$9K |
| Texas | $117-$43K | $88-$33K | $34-$11K |
| Maryland | $96-$29K | $38-$24K | $11-$6K |
| West Virginia | $95-$69K | $64-$40K | $18-$9K |
| Connecticut | $95-$69K | $43-$37K | $14-$7K |
| District of Columbia | $90-$84K | $43-$38K | $13-$11K |
| | | | |
| California | $75-$28K | $49-$18K | $21-$5K |
| Source: Medical Liability Monitor October 2002 Report. Highest and lowest premiums reported for internal medicine, general surgery and ob-gyn physicians. | | | |

The effect of these premiums on what patients must pay for care can be seen from an example involving obstetrical care. If an obstetrician delivers 100 babies per year (which is roughly the national average) and the malpractice premium is $200,000 annually (as it is in Florida), each mother (or the government or her employer who provides her health insurance) must pay approximately $2,000 merely to pay her share of her obstetrician's liability

insurance. If a physician delivers 50 babies per year, the cost for insurance premiums per baby is twice as high, about $4,000. It is not surprising that expectant mothers are finding their doctors have left states with litigation systems imposing these costs.

Nursing homes are a new target of the litigation system. From 1990 to 2001, the average size of claims tripled, and the number of claims increased from 3.6 to 11 per 1,000 beds.[85] Premium increases paid by nursing homes are rising rapidly because of dramatic increases in both the number of lawsuits and the size of awards. Between 1995 and 2001, the average premium increased from $240 per occupied skilled nursing bed per year to $2,360. These costs vary widely across states, again in relation to whether a state has implemented reforms that improve the predictability of the legal system. Florida ($11,000) had one of the highest per bed costs in 2001.[86] Nursing homes in Mississippi have been faced with increases in total premiums as great as 900% in the past two years.[87] Since Medicare and Medicaid pay most of the costs of nursing home care, these increased costs are borne by taxpayers, and consume resources that could otherwise be used to expand health (or other) programs.

# V. INSURERS ARE LEAVING THE MARKET

The litigation crisis is affecting patients' ability to get care not only because many doctors find the increased premiums unaffordable but also because liability insurance is increasingly difficult to obtain at any price, particularly in non-reform states. Demonstrating and exacerbating the problem, several major carriers have stopped selling malpractice insurance.

- St. Paul Companies, which was the largest malpractice carrier in the United States, covering 9% of all doctors, announced in December 2001 that it would no longer offer coverage to any doctor in the country.[88]

- MIXX pulled out of every state; it has reorganized and sells only in New Jersey.

- PHICO and Frontier Insurance Group have also left the medical malpractice market.[89, 90]

- Doctors Insurance Reciprocal stopped writing group specialty coverage at the beginning 2002.[91]

Fifteen insurers have left the Mississippi market in the past five years.[92] The number of medical liability insurance companies active in Florida dropped from 66 in the late 1990s to only 12 in 2002.[93] These remaining companies have limited capacity to write new policies for providers whose carriers have departed the market.[94]

According to the Missouri Insurance Commissioner's office, of the 32 companies writing medical malpractice coverage in the state in 2001, only 8 are still writing policies for doctors.[95] The companies that are still in business are charging more and offering fewer discounts. Five specialties in Missouri are facing particular problems in getting coverage: obstetrics-gynecology, orthopedics, neurosurgery, radiology and trauma. Similarly, the two major carriers of professional liability coverage for doctors in Iowa, MMIC and PIC Wisconsin, have reached near capacity (which limits their ability to write new or additional coverage).[96]

The National Association of Insurance Commissioners (NAIC) has examined the increasing unwillingness of insurers to sell malpractice insurance and explains the reasons for this crisis:

> "The reason insurers are not writing, or are pulling back from medial malpractice insurance, is because there are many other lines of insurance that offer more opportunities for profit at a lower risk. The uncertainties and historical return in this line of business

lead many commercial insurers to commit capital in other lines of commercial insurance. It is our experience this market will remain volatile in some states until such time as claims costs stabilize."[97]

# VI. STATES WITH REALISTIC LIMITS ON NON-ECONOMIC DAMAGES ARE FARING BETTER

The insurance crisis is acute in states that have not reformed their litigation systems. Over the last two years, states with limits of $250,000 or $350,000 on non-economic damages have seen average combined highest premium increases of 18%, but states without reasonable limits on non-economic damages (in states representing almost half of the entire United States population) have seen average increases of 45%, as shown in Table 6.

**TABLE 6. Comparison of States with Caps to States without Meaningful Non-Economic Caps (Average Highest Premium Increase)**

| States with Caps ≤ $250,000 | | | | States without Caps | | | |
|---|---|---|---|---|---|---|---|
| | 2001 | 2002 | Avg, | | 2001 | 2002 | Avg, |
| California | 20% | 20% | | Arkansas | 18% | 104% | |
| Indiana | 16% | 55% | | Connecticut | 50% | 28% | |
| Montana | 21% | 35% | | Florida+ | 47% | 59% | |
| Utah | 5% | 35% | | Georgia | 32% | 37% | |
| AVERAGE | 16% | 36% | | Illinois | 52% | 72% | |
| AVERAGE over 2 years | | | 26% | Mississippi | 0% | 66% | |
| **States with Caps < $350,000** | | | | Nevada | 35% | 50% | |
| | 2001 | 2002 | | New Jersey | 24% | 13% | |
| California | 20% | 20% | | North Carolina | 0% | 50% | |
| Hawaii | 0% | 5% | | Ohio+ | 60% | 60% | |
| Indiana | 16% | 55% | | Oregon | 56% | 80% | |
| Michigan | 39% | 13% | | Pennsylvania | 77% | 62% | |
| Montana | 21% | 35% | | Rhode Island | 60% | 9% | |
| New Mexico | 12% | 42% | | Tennessee | 17% | 49% | |
| North Dakota | 0% | 15% | | Texas+ | 32% | 45% | |
| South Dakota | 0% | 20% | | Virginia | 37% | 74% | |
| Utah | 5% | 35% | | Washington | 55% | 6% | |
| Wisconsin | 5% | 5% | | West Virginia | 44% | 46% | |
| AVERAGE | 13% | 24% | | AVERAGE | 39% | 51% | |
| AVERAGE over 2 years | | | 18% | AVERAGE over 2 years | | | 45% |

SOURCE: Medical Liability Monitor, October 2001 and October 2002. Percentages represent the combined average of the highest premium increases for OB/GYNs, Internists, and General Surgeons among select states, 2002. Average highest premium increase is derived from the highest potential premium increase among internal medicine, general surgery or obstetrics/gynecology specialists in that state during 2002. These combined averages are not weighted.

+ Florida imposes a cap of $250,000-$350,000 unless neither party demands binding arbitration or the defendant refuses to arbitrate. Florida is not considered to have a meaningful cap on non-economic damages because of the confusion associated with the arbitration provision. An Ohio statute limiting non-economic damages was declared unconstitutional in 1999. The Texas statute limits damages ($1.4 million in 2002) in wrongful death cases only; the statute had applied to all negligence actions but was ruled unconstitutional in 1990.

As Table 7 below shows, there is a substantial difference in the level of medical malpractice premiums in states with meaningful caps and states without meaningful caps. For example, internists in Los Angeles are charged less than one-half of the premium charged internists in Ft. Lauderdale and Miami. General surgeons and obstetrician-gynecologists in Florida are charged three to four times as much as their peers in California.

In each instance, the premiums in California are less than those charged to specialists in non-reform states. The success of California, and other states that have taken similar actions to rein in the excesses of the litigation system, is not accidental. It is a result of a willingness to confront the problem and enact reforms. In the early 1970s California faced an access crisis like that facing many states now. With bi-partisan support, including leadership from Jerry Brown, then Governor, and from Henry Waxman, then chairman of the Assembly's Select Committee on Medical Malpractice, California enacted comprehensive changes to make its medical liability system more predictable and rational. The Medical Injury Compensation Reform Act of 1975 (MICRA) made a number of reforms, in particular:

- Placing a $250,000 limit on non-economic damages while continuing unlimited compensation for economic damages.

- Shortening the time in which lawsuits could be brought to three years (thus ensuring that memories would still be fresh and providing some assurance to doctors that they would not be sued years after an event that they may well have forgotten).

- Providing for periodic payment of damages to ensure the money is available to the patient in the future.

California has more than 25 years of experience with this reform. It has been a success. Doctors are not leaving California. Insurance premiums have risen much more slowly than in the rest of the country without any effect on the quality of care received by residents of California. Insurance premiums in California have risen by 167% over this period while those in the rest of the country have increased 505%.[98]

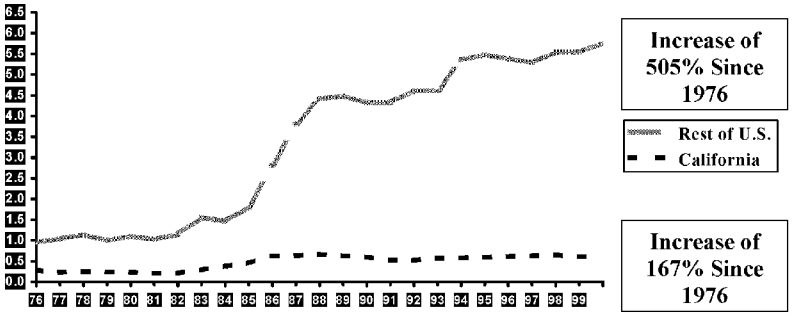
States that do not have the benefit of reforms like California's will continue to experience larger payments for non-economic losses, larger settlements, higher premiums, and reduced access to care. The National Association of Insurance Commissioners--the organization of the state insurance regulators--is concerned about the premiums charged by medical malpractice insurers--concerned that they are too low. Referring to the amounts paid out on claims and defense costs, the NAIC recently warned, "Because of extremely high loss ratios in many states, regulators concerns have been with rate inadequacy, and not excessiveness or unfair discrimination."[99]

| TABLE 7: Malpractice Liability Rate Ranges by Specialty by Geography as of October 2002 | | | |
|---|---|---|---|
| | Cap on Non-Economic Damages | Low | High |
| **INTERNISTS** | | | |
| State Wide Data | | | |
| Wisconsin | $350,000 | $4,500 | $6,000 |
| Montana | $250,000 | 7,000 | 7,900 |
| Utah | $250,000 | 7,900 | 10,600 |
| Hawaii | $350,000 | 7,100 | 7,100 |
| Connecticut | No cap | 7,400 | 13,800 |
| Washington | No cap | 6,700 | 9,800 |
| Metropolitan Area Data | | | |
| California (Los Angeles area) | $250,000 | $8,800 | $21,200 |
| Pennsylvania (Urban Philadelphia area) | No cap | 11,000 | 12,000 |
| Nevada (Las Vegas area) | No cap | 17,400 | 23,600 |
| Illinois (Chicago area) | No cap | 19,900 | 31,700 |
| Florida (Miami and Ft. Lauderdale areas)* | No cap | 26,800 | 56,100 |
| **GENERAL SURGEONS** | | | |
| State Wide Data | | | |
| Wisconsin (state wide) | $350,000 | $16,000 | $19,300 |
| Montana (state wide | $250,000 | 21,900 | 31,400 |
| Utah (state wide) | $250,000 | 35,500 | 39,100 |
| Hawaii (state wide) | $350,000 | 25,800 | 25,800 |
| Connecticut (state wide) | No cap | 36,900 | 43,400 |
| Washington (state wide) | No cap | 20,100 | 35,200 |
| Metropolitan Area Data | | | |
| California (Los Angeles area) | $250,000 | $30,700 | $49,400 |
| Pennsylvania (Urban Philadelphia area) | No cap | 50,100 | 104,400 |
| Nevada (Las Vegas area) | No cap | 59,800 | 85,100 |
| Illinois (Chicago area) | No cap | 63,600 | 75,600 |
| Florida (Miami and Ft. Lauderdale areas)* | No cap | 95,500 | 174,300 |
| **OBSTETRICIANS/GYNECOLOGISTS** | | | |
| State Wide Data | | | |
| Wisconsin (state wide) | $350,000 | $21,500 | $27,800 |
| Montana (state wide | $250,000 | 33,900 | 52,200 |
| Hawaii (state wide) | $350,000 | 42,900 | 42,900 |
| Utah (state wide) | $250,000 | 46,900 | 60,000 |
| Connecticut (state wide) | No cap | 69,500 | 95,000 |
| Washington (state wide) | No cap | 30,900 | 51,900 |
| Metropolitan Area Data | | | |
| California (Los Angeles area) | $250,000 | $54,600 | $65,400 |
| Pennsylvania (Urban Philadelphia area) | No cap | 64,300 | 116,400 |
| Nevada (Las Vegas area) | No cap | 93,200 | 141,800 |
| Illinois (Chicago area) | No cap | 102,400 | 110,100 |
| Florida (Miami and Ft. Lauderdale areas)* | No cap | 136,200 | 210,600 |

Source: Medical Liability Monitor, October 2002: Shook, Hardy, Bacon, L.L.P., October 9, 2001.
* Florida imposes caps of $250,000-350,000 unless neither party demands binding arbitration or the defendant refuses to arbitrate. Florida is not considered to have a meaningful cap on non-economic damages because of the confusion associated with the arbitration provision.

The litigation system must be reformed to protect Americans' access to high quality health care.

FIGURE 1. Premium Growth: California vs. U.S. Premiums 1976-2000
(Billions of dollars)




SOURCE: NAIC Profitability Study, 2000.

# VII. THE PRESIDENT'S FRAMEWORK FOR IMPROVING THE MEDICAL LITIGATION SYSTEM

Federal and state action is needed to address the impact of the medical litigation crisis on health care costs and the quality of care.

## 1. Establish a Fair, Predictable, and Timely Process

As years of experience in many states have proven, reasonable limits on the amount of non-economic damages that are awarded significantly restrain increases in the cost of insurance premiums. These reforms improve the predictability of the medical litigation system, reducing incentives for filing frivolous suits and for prolonged litigation. Greater predictability and more timely resolution of cases means patients who are injured can get fair compensation more quickly. They also reduce health care costs, enabling Americans to get more from their health care spending and enabling federal health programs to provide more relief. They improve access to care, by making insurance more affordable and available. They also improve the quality of health care, by reducing defensive medicine and enabling doctors to spend significantly more time focusing on patient care. President Bush has, on several occasions, urged Congress to give all Americans the benefit of these reforms, eliminate the excesses of the litigation system, and protect patients' ability to get quality care.

The President supports federal reforms in medical liability law that would implement these proven steps for improving our health care system:

- Improve the ability of all patients who are injured by negligence to get quicker, unlimited compensation for their "economic losses," including the loss of the ability to provide valuable unpaid services like care for children or a parent.

- Ensure that recoveries for non-economic damages could not exceed a reasonable amount ($250,000).

- Reserve punitive damages for cases that justify them--where there is clear and convincing proof that the defendant acted with malicious intent or deliberately failed to avoid unnecessary injury to the patient--and avoid unreasonable awards (anything in excess of the greater of two times economic damages or $250,000).

- Provide for payment of a judgment over time rather than in one lump sum--and thus ensure that the money is there for the injured patient when needed.

- Ensure that old cases cannot be brought years after an event when medical standards may have changed or witnesses' memories have faded, by providing that a case may not be brought more than three years following the date or injury or one year after the claimant discovers or, with reasonable diligence, should have discovered the injury.

- Informing the jury if a plaintiff also has another source of payment for the injury, such as health insurance.

- Provide that defendants pay any judgment in proportion to their fault, not on the basis of how deep their pockets are.

The success of the states that have adopted reforms like these shows that malpractice premiums could be reduced by 34%.[100] The savings to the Federal Government resulting from reduced malpractice premiums could be $4.8 billion.[101]

In October 2002, the House of Representatives passed H.R. 4600--a bill introduced by Congressman Jim Greenwood with almost 100 bipartisan cosponsors. The Senate did not act. The bill was reintroduced in the House in February 2003, as H.R. 5. Enactment of similar legislation, with improvements to ensure that its meaningful standards will apply nationally, will be a significant step toward the goals of affordable, high-quality health care for all Americans, and a fair and predictable liability system for compensating injured patients.

In addition, there are other promising approaches for compensating patients injured by negligence fairly and without requiring them to go through full-scale, time-consuming, and expensive litigation. States should also adopt and evaluate alternatives to litigation.

Early Offers is one innovative approach.[102] This would provide a new set of balanced incentives to encourage doctors to make offers, quickly after an injury, to compensate the patient for economic loss, and for patients to accept. It would make it possible for injured patients to receive fair compensation quickly, and over time if any further losses are incurred, without having to enter into the litigation fray. Because doctors and hospitals would have an incentive to discover adverse events quickly in order to make a qualifying offer, it would lead to prompt identification of quality problems. The money that otherwise would be spent in conducting litigation would be recycled so that more patients get additional recovery, more quickly, with savings left over to the benefit of all Americans. It may also be possible to implement an administrative form of Early Offers as an option for patients who are injured in the course of receiving care under certain federal health programs.

A second innovative approach involves strengthening medical review boards to reduce claims of malpractice. Boards with special expertise in the technical intricacies of health care can streamline the fact gathering and hearing process, make decisions more accurately, and provide compensation more quickly and predictably than the current litigation process. Physicians must have confidence that the "legal system will get the facts right in the first place".[103] As with Early Offers, incentives are necessary for patients and health care providers to submit cases to the boards and to accept their decisions.

The Administration intends to work with states on developing and implementing these alternatives to litigation, so that injured patients can be fairly compensated quickly and without the trauma and expense that litigation entails.

## 2. Improve Health Care Quality Through Litigation Reform

Medical professionals, not lawyers, are the key to quality care. High quality care that achieves the best possible patient outcomes makes litigation unnecessary. The Administration is already taking many steps to improve quality of care.

The ability of Americans to work with their doctors to choose and control their own health care is an important ingredient of quality. The people who are most affected by the quality of care--patients and their families--should be the ones deciding how and from whom they obtain their health care. To do so, they need helpful information.

The Administration is undertaking a number of activities to promote quality by increasing and improving the information available to patients, and taking other steps to make the system safer and more effective. Some specific activities include:

- Providing quality information about nursing homes on the Internet to enable families to make comparisons and informed judgments.

- Promoting the use of information technology to provide better real-time information for doctors, to include all the relevant information in the patient's record and to make it accessible no matter where the patient is.

- Promoting the introduction and use of bar coding for dispensing prescription drugs to reduce errors. This action alone stands to dramatically reduce the number of medication errors in hospitals, and reduce the costs to society of preventable drug adverse events--recently estimated total direct and indirect costs to society to be a staggering $177 billion yearly.

- Adopting comprehensive standards necessary to make the creation of an electronic health care record possible. This would make a patient's medical records available across different care sites, and to the patient.

- Encouraging disease management programs that can improve the quality of care for people with asthma and diabetes.

- Promoting computer software that hospitals can use to identify quality problems, assisting in quality improvement activities.

The Administration will work to expand these efforts, to give patients and their doctors the information they need to make informed and appropriate medical decisions, while protecting the confidentiality of sensitive information from inappropriate uses.

One of the key ingredients to reducing errors is optimizing doctors' to improve patients' health care. We must encourage them and other experts to identify problems before they result in injury and to develop better ways of providing care.

Researchers have found that most errors are system failures, rather than individual faults. Doctors could do their job correctly, and most errors would still occur. In addition, since human error inevitably occurs, built-in systems should automatically prevent, detect and/or correct errors before they occur. Continuous quality improvement processes, which have been effective in many other "high-risk" sectors, focus on finding ways to design work processes so that better results and fewer errors can be achieved. This requires measurement and analysis of the ways health care is provided, and the results of care for patients. By encouraging the experts to work both inside their own organization and with outside groups to share information on how medical errors or "near misses" occur and ways to prevent them, health care organizations have begun to develop tools to prevent injury and increase knowledge of how errors occur.

Success in improving health care practices to prevent errors and deliver high-quality care, however, requires a legal environment that encourages health care professionals and organizations to work together to identify problems in providing care, evaluate the causes, and use that information to improve care for all patients.

A principal obstacle to taking these steps is the fear by doctors, hospitals, and nurses that reports on adverse events and efforts to improve care will be subject to discovery in lawsuits. As several distinguished physicians recently wrote, "for reasons that include liability issues and a medical culture that has discouraged open discussion of mistakes, the power of individual case presentation, so important in the physician's clinical medicine education, has not been harnessed to educate providers about medical errors."[104]

A number of states have enacted peer review statutes that protect the confidentiality of information within hospitals and other health care entities.

Confidentiality protections provided by law for specific activities also have proven successful in identifying problems and reducing medical errors:

- The National Nosocomial Infections Surveillance System, operated by the Centers for Disease Control, receives voluntary reports from hospitals on hospital-acquired infections. It has reduced these infections by 34%. The system works because federal law assures participating hospitals that information supplied by them will be kept confidential.

- MedWatch is a voluntary Medical Products Reporting System operated by the Food and Drug Administration. Adverse events concerning medical devices and drugs may be reported to it to identify problem areas. Names of the reporting doctors and hospitals, and the name of patients involved, are not releasable under the Federal Freedom of Information Act.

- The Department of Veterans Affairs maintains a Patient Safety Reporting System to learn about issues related to patient safety. To encourage reporting, federal law provides that reports relating to new safety ideas, close calls, or unexpected serious injury are confidential and privileged. This is based on the successful system operated by the National Aeronautics and Space Administration for aviation safety reporting.

- New York State operates the New York Patient Occurrence Reporting and Tracking System. Adverse events are reported to it. New York State law prevents disclosure of reports under the state's freedom of information law.

The IOM report "To Err is Human" noted that while many of the legal protections developed by states have promise, many current state peer review statutes do not go far enough. For example, these laws typically provide legal protection for communications within individual institutions, and usually only for certain committees. These laws do not reflect the systemic nature of health care as it is now provided. They do not provide a way to obtain data from various providers at one time and to compare results. Many states, moreover, do not have any peer review statutes at all. The IOM, therefore, recommended legislation to ensure that peer review proceedings and reports remain confidential.[105]

The President believes that new, good faith efforts to improve the quality and safety of health care should be protected and encouraged, not penalized by new lawsuits. President Bush has on several occasions urged Congress to address this problem by enacting legislation that will give health professionals the confidence necessary to expand their reporting of problems in the health care system.

Following the President's request, and with assistance from the Administration, legislation was introduced in both Houses of Congress last year that would provide confidentiality and other protections for information reported to Patient Safety Organizations and for their collaborative efforts to improve care. A tri-partisan Bill that reflects the President's goals, sponsored by Senators Jeffords, Breaux, Frist, and Gregg, was introduced in the Senate last year (S. 2590). The House Energy and Commerce Committee and the Ways and Means Committee recently reported similar bills (H.R. 663 and H.R. 877 respectively). Passage of this kind of legislation will ensure that patient safety and quality reports are given the protection they deserve.

The assurance of confidentiality is a proven approach to increase reporting by doctors, nurses, and other health care providers. With more information, quality experts will be better able to identify problems and recommend improvements in a proactive way. Rather than reacting to an avoidable injury or quality problem after it occurs, without benefit of careful and systematic review, medical professionals will be able to find system weaknesses and fix them before a patient is injured. Passage of the legislation will improve the quality of health care.

# VIII. IT IS SPECIOUS TO BLAME INSURERS FOR THE CRISIS

Trial lawyers, and interest groups associated with them, do not dispute the fact that there is an insurance crisis. They argue, however, that the fault lies with the insurance companies themselves--not the litigation system--and that the cure is not to impose a reasonable limit on the amount of non-economic damages, but instead for doctors to form their own insurance companies.

The trial lawyers' advice to doctors to organize their own insurance companies overlooked the fact that doctors have already done this. Physician-owned companies currently insure more than 60% of doctors.[106] A number of doctor-owned companies were created in the 1970s, when many doctors were unable to obtain coverage. Not surprisingly, however, these companies have suffered the same increases in claim costs as the commercial companies.[107] The reason is that the overriding cost element--the litigation the excesses of the litigation system--affects all insurers regardless of their form of ownership.

The trial lawyers assert, however, that the problem is not the increase in the amounts insurers pay out but the insurers' management practices. They argue that insurers are making up for bad investments in the stock market; they point out that interest rates have declined; and they complain that the premiums the insurers charged in the 1990s were too low. From these statements they somehow seek to persuade us that the litigation system is not causing the crisis.

If the factors alleged by the trial lawyers explained the problem, insurers in every state would be forced to increase their premiums to the same extent. But the fact is that the insurers are being forced to increase their premiums more rapidly and more steeply in the non-reform states than in states that have placed reasonable limits on non-economic damages.

The difference in premiums among the different states cannot be explained by management practices. When St. Paul Companies pulled out of the malpractice insurance market in 2002, they continued to offer other lines of insurance. The difference is the litigation climate in which the different lines of insurance are required to operate.

The argument that the problem is caused by bad investments is similarly specious. In fact, investments by medical malpractice companies have been conservative. Most states have laws that specifically limit the percentage of assets an insurance company can put in stocks. Over the last five years, the industry wide allocation of assets into equities has been relatively constant. Medical malpractice insurers' investments in equities as a percentage of total assets, as shown below, has been 11% or less.

| TABLE 8. Five Year Historical Asset Allocation Table for Medical Malpractice Carriers | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Asset Class | | | | | | |
| | Cash | Corp | Equity | Govt | Muni | Other | Pref |
| | % | % | % | % | % | % | % |
| 1997 | 4.98 | 27.61 | 8.87 | 21.12 | 34.19 | 1.27 | 1.96 |
| 1998 | 5.83 | 26.51 | 8.93 | 18.77 | 36.44 | 1.89 | 1.64 |
| 1999 | 5.39 | 28.52 | 10.78 | 15.54 | 36.89 | 1.37 | 1.51 |
| 2000 | 6.48 | 30.89 | 9.72 | 14.90 | 35.03 | 1.40 | 1.57 |
| 2001 | 7.74 | 34.84 | 9.03 | 13.73 | 31.41 | 1.53 | 1.73 |
| Brown Brothers Harriman & Co., 2002. | | | | | | | |

Insurers' returns on bonds have decreased. Interest rates have declined in the country and the world. The amounts earned on investments help pay claims. But the investment climate is a fact, beyond the control of the insurance companies. Their need to raise premiums can best be reduced by controlling increases in the amounts they must pay out--particularly for unreasonable amounts of non-economic damages. Neither asset allocation nor investment income correlates to, much less causes, the current medical malpractice crisis. Specifically, Brown Brothers Harriman & Company analyzed the relationship between premiums and the change in investment yields among malpractice insurers. The results showed that the performance of the economy and interest rates do not determine medical malpractice premiums.[108]

While the trial lawyers' argue that insurers' premiums were too low in prior years, premiums are affected by the competitive climate, in the context of costs that all participants must bear. If premiums were "too low" in previous years, this just means that physicians were charged less then than the trial lawyers believe they should have been. It does not change the costs the insurers are forced to pay or the total amount of premiums that would have to be collected; even under the trial lawyers' theory of how the insurers should price their product, some undetermined amount of the premiums being charged currently should have been collected in previous years. It would not change the total revenue needs of the insurers (which are determined by the amount they must pay out).

The trial lawyers' argument that the root of the crisis lies in the organizational form or management practices of the insurers thus has no validity.

Trial lawyers also attempt to shift the blame to insurers by asserting that they have engaged in anti-competitive practices. The NAIC has reviewed this assertion and reported that "insurance regulators have not seen evidence that suggests medical malpractice insurers have engaged or are engaging in price fixing, bid rigging, or market allocation."[109] Rather, the NAIC also says, "the preliminary evidences points to rising loss costs and defense costs associated with litigation as the principal drivers of medical malpractice [insurance] prices."[110]

Consistent with their failure to focus on the costs the insurers must bear, the trial lawyers argue, finally, that California's MICRA legislation, placing reasonable limits on non-economic compensation, is not the cause of California's success in avoiding the increase in premiums that non-reform states have experienced. They point, instead, to a change in the law of California in 1988 that imposed rate review on the premiums of insurance companies. Regulation, however, cannot avoid the need for insurers to receive a premium sufficient to pay their expenses and make a fair profit. Nor does California's regulation of premiums differentiate it from the rest of the country. As the NAIC explains, "Almost all states have rating laws for property and casualty insurers, including medical malpractice. These rating laws require that insurance rates not be excessive, inadequate or unfairly discriminatory."[111] California's adoption of increased regulation in 1988 therefore does not explain its ability to avoid the rapid increase in premiums and access problems that states without reasonable caps have experienced.

In fact, premiums in the rest of the country already were increasing more rapidly than in California before 1988, as shown in Figure 1. What makes the difference is the litigation system, not insurance reforms.

# CONCLUSION

Americans' access to high quality care is threatened by the excesses of the litigation system. Higher costs for defending claims, larger judgments, particularly for subjective non-economic damages in states that have not introduced reasonable limits on non-economic damages, and settlements that reflect the trend of jury awards are raising insurers' costs. Insurers must raise premiums to pay claims. Patients are paying the price in reduced access to care as doctors increasingly leave the states with the highest costs, retire, or restrict their practice. Patients are being injured. The crisis is going to get worse if we do not act; the insurance regulators believe premiums in many states are currently too low. States like California that have placed reasonable limits on the amount of non-economic damages are not suffering the same high premiums and reductions of access to care as the states that do not have such limits. The Administration supports legislation that will ensure that all states have the benefit of reasonable limits, which will stabilize their insurance markets and encourage doctors to continue to practice there.

In addition, legislation is necessary to protect efforts by hospitals, doctors, and other experts to improve quality by encouraging reporting of needed information and collaborative use of it. Reports about safety problems and "close calls" in the course of health care are essential to improving quality, but the litigation system now discourages reporting and impedes the exchange of information and collaboration necessary to improve quality. The efforts of health professionals to improve quality will be enhanced if the information developed for these purposes is protected from use in the litigation system. Quality of care can best be protected, and improved, by health care experts, not by lawyers.

Enactment of these two reforms will improve the litigation system, increase access to health care, reduce the cost of health care, and improve quality. It will do so while ensuring that injured patients have the same access to information about their care as they do now, and that they can recover all their actual losses and a reasonable amount of non-economic damages as well.

[1] US Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing our Medical Liability System, July 25, 2002.

[2] Website http://aspe.hhs.gov/daltcp/home.shtml.

[3] See Table 6. These rates reflect average highest premium increases among internal medicine, general surgery and obstetrics-gynecology specialists.

[4] See Table 6. These rates reflect average highest premium increases among internal medicine, general surgery and obstetrics-gynecology specialists.

[5] Philadelphia Inquirer, August 30, 2002.

[6] ASPE/HHS Communication, September 25, 2002.

[7] The Times Leader, August 10, 2002.

[8] Rep. Ellen Bard, ASPE/HHS Communication, December 13, 2002.

[9] The Impact of Medical Malpractice Insurance and Tort Reform on Washington's Health Care Delivery System, Washington State Medical-Education and Research Foundation, September 2002.

[10] Robin Palmer, "Doctors, Lawyers Square off in malpractice insurance debate", Rutland Herald, 1/11/2003.

[11] Website http://massmed.org, Massachusetts Medical Society, December 3, 2002.

[12] Las Vegas Journal Review, August 29, 2002.

[13] Washington Post, July 4, 2002.

[14] Los Angeles Times, March 4, 2002.

[15] Las Vegas Journal Review, August 29, 2002.

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[60] Office of the Assistant Secretary for Planning and Evaluation using Council of Economic Advisors' Estimates, February 2003.

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[63] Total Federal health care expenditures in 2002 were estimated to be $562 billion. Estimates show that medical liability reforms would lead to a decline in medical expenses from defensive medicine amounting to 5% to 9% of total medical costs (See Kessler, D. and McClellan, M, 1996). Our estimate of the savings to the Federal Government from reduced defensive medicine would range from $28.1 billion (5% of $561.837 billion) to $50.6 billion (9% of $561.837 billion).

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[67] Illinois Department of Insurance, Casualty Actuarial Section, Medical Malpractice Claims Study, 2001.

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[97] Mike Pickens, President of the National Association Of Insurance Commissioners, in a letter to Senator Judd Gregg, Chair, U.S. Senate Committee on Health, Education, Labor, and Pensions, February 7, 2003.

[98] NAIC Profitability by Line by State, 2001, presented before House Judiciary Committee by PIAA June, 2002.

[99] Mike Pickens, President of the National Association Of Insurance Commissioners, in a letter to Senator Judd Gregg, Chair, U.S. Senate Committee on Health, Education, Labor, and Pensions, February 7, 2003.

[100] Zuckerman, Stephen, Bovbjerg, Randall R., and Sloan, Frank, "Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums," Inquiry 27: 167-182, Summer 1990.

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[104] "Learning from our Mistakes: Quality Grand Rounds, a New Case-Based Series on Medical Errors and Patient Safety," Annuals of Internal Medicine, Volume 136, Number 11, June 4, 2002.

[105] IOM Report, "To Err is Human: Building a Safer Health System," 2000.

[106] Statement of the Physician Insurers Association of America before a joint hearing of the US Senate Judiciary Committee and Health, Education, Labor and Pensions Committee, February 11, 2003.

[107] The current President of PIAA, Lawrence Smarr, reported in a presentation at the Health Policy Summit in Jacksonville, FL on December 17, 2002, that he himself once thought that physician-owned malpractice insurance companies would be able to restrain costs more effectively than commercial companies. He left employment with a commercial company to work for a physician-owned one. He described, however, that experience taught him otherwise. Physician owned and commercial carriers face the same challenges--the escalating losses that are generated by the litigation system.

[108] Ramacachandran, Raghu, "Did Investments Affect Medical Malpractice Premiums?," Brown Brothers Harriman & Company, January 21, 2003.

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[110] Mike Pickens, President of the National Association Of Insurance Commissioners, in a letter to Senator Judd Gregg, Chair, U.S. Senate Committee on Health, Education, Labor, and Pensions, February 7, 2003.

[111] Mike Pickens, President of the National Association Of Insurance Commissioners, in a letter to Senator Judd Gregg, Chair, U.S. Senate Committee on Health, Education, Labor, and Pensions, February 7, 2003.

**H.R. 5 (the HEALTH Act): 10 Questions and Answers**

Here are 10 questions and 10 answers regarding why Congress needs to pass H.R. 5.

**1. What Problem Does H.R. 5 Address?**

A national insurance crisis, driven by litigation, is ruining the nation's essential health care system. Medical professional liability insurance rates have soared, causing major insurers to either drop coverage or raise premiums to unaffordable levels. Doctors and other health care providers are being forced to abandon patients and practices, particularly in high-risk specialties such as emergency medicine, brain surgery, and obstetrics and gynecology. Women are being particularly hard hit, as are low-income neighborhoods and rural areas. The Department of Health and Human Services concluded in a July report that the average award in medical malpractice cases has risen 76% in recent years, and that "mega-awards" for "pain and suffering" that drive up medical professional liability premiums occur only in states without any limits on what a plaintiff can recover.[1] Before the 1960's, only one physician in seven had ever been sued in their entire lifetime,[2] whereas today's rate is about one in seven per year.[3]

**2. What Does H.R. 5 Do?**

Federal legislation called the HEALTH Act (H.R. 5), is modeled after California's quarter-century old and highly successful health care litigation reforms. Its enactment will make health care more accessible in the United States. California's Medical Injury Compensation Reform Act ("MICRA"), enacted in 1975, has proved immensely successful in increasing access to affordable medical care in California. It is the only proven legislative solution to the current crisis in access to health care. MICRA's reforms, which are included in the HEALTH Act, include a $250,000 cap on noneconomic damages; limits on the contingency fees lawyers can charge; and authorization for defendants to introduce evidence showing the plaintiff received compensation for losses from outside sources (to prevent double recoveries). The HEALTH Act also includes provisions creating a "fair share" rule, by which damages are allocated fairly, in direct proportion to fault; reasonable guidelines on the award of punitive damages; and a safe harbor from punitive damages for products that meet applicable FDA safety requirements.

**3. What Doesn't H.R. 5 Do?**

H.R. 5 does not limit in any way an award of "economic damages" from anyone responsible for harm. Economic damages include anything whose value can be quantified, including lost wages or home services (including lost services provided by stay-at-home mothers), medical costs, the costs of pain-reducing drugs, therapy, and lifetime rehabilitation care, and anything else to which a receipt can be attached. Only economic damages – which the federal legislation does not limit – can be used to pay for drugs and services that actually reduce pain. Nothing in H.R. 5 prevents juries from awarding very large amounts to victims of medical malpractice, including stay-at-home mothers and children.

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[1] Department of Health and Human Services, "Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System" (July 24, 2002) at 9-10 ("These mega-awards for non-economic damages have occurred (as would be expected) in states that do not have limitations on the amounts that can be recovered.").

[2] *See* "Opinion Survey of Medical Professional Liability," JAMA 164:1583-1594 (1957).

[3] *See* R. Bovbjerg, "Medical Malpractice: Problems & Reforms," The Urban Institute, Intergovernmental Health Policy Project (1995).

California's legal reforms cap non-economic damages at $250,000, but do not cap quantifiable economic damages. In just the last few years, juries in California have awarded the following in economic damages to medical malpractice victims: an $84,250,000 award to a 5 year-old boy, a $59,317,500 award to a 3 year-old girl, a $50,239,557 award to a 10 year-old boy, a $12,558,852 award to a 30 year-old homemaker, and a $27,573,922 award to a 25 year-old woman. In those very rare cases in which a plaintiff was injured yet can demonstrate absolutely no quantifiable economic losses, under H.R. 5 that plaintiff can still get up to $250,000 in noneconomic damages and up to $250,000 in punitive damages, for a total of $500,000 (half a million dollars) in damages even when absolutely no quantifiable damages at all result from an alleged injury. Further, the HEALTH Act's limits on attorneys fees – the same as those provided for in California – will reduce lawyers' incentives to bring frivolous lawsuits while allowing more money to go directly to injured patients.

H.R. 5 also does not prevent large awards to medical malpractice victims who suffer disfigurement. Loses due to disfigurement can be economically quantified. The Veterans Administration, for example, has a rating schedule that quantifies the economic costs of disfigurement,[4] and that schedule has been fairly compensating our men and women in the armed forces for decades.

H.R 5 also does not preempt any state law that limits damages at specific amounts, be they higher or lower than the limits provided for in H.R. 5.

**4. What Research Supports H.R. 5?**

The best research confirms that litigation reforms such as those in the HEALTH Act reduce medical professional liability premiums. According to the Congressional Budget Office, "certain tort limitations, primarily caps on awards and rules governing offsets from collateral-source benefits, effectively reduce average premiums for medical malpractice insurance. Consequently, CBO estimates that, in States that currently do not have controls on malpractice torts, [the HEALTH Act] would significantly lower premiums for medical malpractice insurance from what they would otherwise be under current law ... CBO estimates that, under [the HEALTH Act], premiums for medical malpractice insurance ultimately would be an average of 25 percent to 30 percent below what they would be under current law."[5]

Mark McClellan, who worked on health policy issues in President Clinton's Treasury Department and who has been described by Senator Ted Kennedy as having "impressive credentials both as a physician and as an economist,"[6] has concluded that "physicians from states enacting liability reforms that directly reduce malpractice pressure [including caps on noneconomic damages] experience lower growth over time in malpractice claims rates and in real malpractice

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[4] *See* L.E. Johnson, Robert D. Ley, and Paul T. Benshoof, "Estimating Economic Loss for a Facially Disfigured Minor: A Case Study," Journal of Legal Economics (July, 1993) (The V.A. rating schedule was obtained from a Veterans Benefits Office at the V.A. Center in St. Paul, Minnesota after being advised that the V.A. disability ratings are for economic loss exclusively. The percentage disability ratings contained in the V.A. S-R-D are based on case study data on economic loss from facial disfigurement. This data was initially collected during World War II by the V.A. and has been updated from that time ... The first component of economic loss is termed social loss. Social loss refers to the additional cost of job search which results from facial disfigurement. The second component of economic loss is what the V.A. terms industrial loss. Industrial loss refers to lost income because of lost earning capacity.").

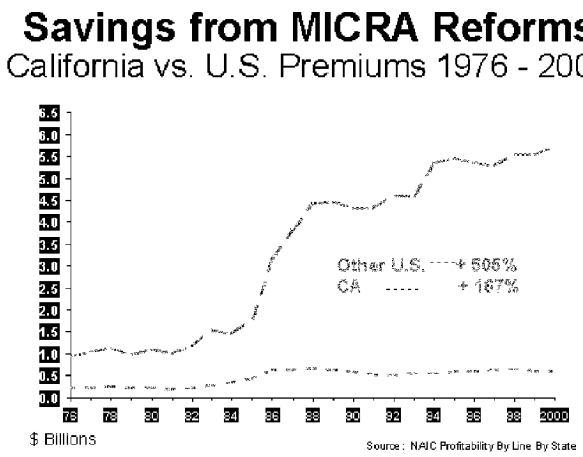
[5] Congressional Budget Office Cost Estimate of H.R. 4600 (the HEALTH Act) (September 24, 2002).

[6] Marc Kaufman, "Bush Adviser Tabbed for FDA," The Washington Post (September 25, 2002) at A25.

insurance premiums."[7]

**5. Have California's Legal Reforms Worked?**

The California Supreme Court, in upholding California's legal reforms -- including the $250,000 cap on pain and suffering damages – stated that the purposes of those reforms are to "provide a more stable base on which to calculate insurance rates" by eliminating the "unpredictability of the size of large noneconomic damage awards, resulting from the inherent difficulties in valuing such damages and the great disparity in the price tag which different juries placed on such losses [and to] promote settlements by eliminating 'the unknown possiblity of phenomenal awards for pain and suffering that can make litigation worth the gamble.'"[8] Cruz Reynoso, Democratic Vice Chairman of the U.S. Civil Rights Commission and a former Justice on the California Supreme Court, wrote in a recent op-ed, "What is obvious about MICRA is that it works and works well ... Our [California] doctors and hospitals pay significantly less for liability protection today than their counterparts in states without MICRA-type reforms."[9] Democratic Senator Dianne Feinstein agrees, saying recently that "I think we can get the California MICRA passed in the Senate and expanded because it stood the test of time. It's workable. It's balanced. It has provided a substantial level of satisfaction."[10] The chart at right, compiled from information provided by the National Association of Insurance Commissioners, shows how California's legal reforms have controlled the annual rate of increase (y-axis) of medical professional liability premiums in California, whereas such premiums have sharply and




[7] *See* Daniel P. Kessler and Mark B. McClellan, "The Effects of Malpractice Pressure and Liability Reforms on Physicians' Perceptions of Medical Care," 60 Law and Contemporary Problems 1: 81-106 (1997), at 105.

[8] *Fein v. Permanent Medical Group*, 38 Cal.3d 137, 163 (1985); *see also Western Steamship Lines, Inc. v. San Pedro Peninsula Hospital* 8 Cal.4th 100, 112 (1984).

[9] Cruz Reynoso, "California's Medical Liability Cure," The Los Angeles Times (February 4, 2003) at B13.

[10] Transcript, CNN with Wolf Blitzer (January 16, 2003).

steadily increased elsewhere: since 1975, premiums paid in California increased 167% while premiums paid in the rest of the country increased 505%. If California's legal reforms were implemented nationwide, we would have to spend 300% less in medical professional liability insurance, and those saved funds (billions of dollars annually) could have gone to patient care.

**6. Why is Federal Reform Necessary?**

Reform at the federal level is necessary to increase workers' access to health care everywhere. We live in an interconnected economy that includes many businesses that operate in many different states. Unlimited liability in some states makes health care costs go up. When health care costs go up in one state, they can affect a company's ability to offer health insurance to employees nationwide. Because of this, CBO concluded that the HEALTH Act would lead to "an increase in the number of employers offering insurance to their employees and in the number of employees enrolling in employer-sponsored insurance, changes in the types of health plans that are offered and increases in the scope or generosity of health insurance benefits."

Federal reform is also necessary because at least 21 activist state supreme courts have judicially nullified legal reforms under their state constitutions and many more may do so unless Congress acts to let doctors treat patients wherever they are, not just where states have enacted legal reforms that can be upheld under their state constitutions.[11] According to a report by the Department of Health and Human Services: "Unless a state has adopted limitations on non-economic damages ... [t]he cost of these awards for non-economic damages is paid by all other Americans through higher health care costs, higher health insurance premiums, higher taxes, reduced access to quality care, and threats to quality of care. The system permits a few plaintiffs and their lawyers to impose what is in effect a tax on the rest of the country to reward a very small number of patients who happen to win the litigation lottery. It is not a democratic process."

H.R. 5 will also save federal taxpayers billions of dollars. Former Democratic Senator George McGovern has written that "Legal fear drives [doctors] to prescribe medicines and order tests, even invasive procedures, that they feel are unnecessary. Reputable studies estimate that this 'defensive medicine' squanders $50 billion a year, enough to provide medical care to millions of uninsured Americans."[12] According to the Department of Health and Human Services, "If reasonable limits were placed on non-economic damages to reduce defensive medicine, it would reduce the amount of taxpayers' money the Federal Government spends by $25.3-44.3 billion per year ... This is a very significant amount. It would more than fund a prescription drug benefit for Medicare beneficiaries and help uninsured Americans obtain coverage through a refundable health credit."[13]

The litigation reforms in the HEALTH Act also will reduce the incidence of medical malpractice because the threat of potentially infinite liability currently prevents doctors from discussing medical errors and looking for ways to improve the delivery of health care. A recent Harris poll asked physicians, "Generally speaking, how much do you think

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[11] *See* Rept. 107-693 pt. 1 (107th Cong., 2d Sess.) at 13 and n.14.

[12] *See* George McGovern and Alan Simpson, "We're Reaping What We Sue," *The Wall Street Journal* (April 17, 2002) at A20.

[13] Department of Health and Human Services, "Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System" (July 24, 2002) at 6 (citing Maulik, Joshi, Anderson, John *et.al.*, "A Systems Approach to Improving Error Reporting," 16 *Journal of Health Care Information Management* 1)).

that fear of liability discourages medical professionals from openly discussing and thinking of ways to reduce medical errors?"an astonishing 59% of physicians replied "a lot."[14]

**7. Is the Crisis in Access to Health Care the Insurers' Fault?**

Over 60% of the doctors in the United States are insured by insurance companies that are owned and operated by other doctors and which operate primarily for their benefit.[15] The idea that those companies would price gouge the very physicians who own them is absurd.

Further, in order for any form of insurance coverage to be viable, the insurance company must receive more in premium dollars and investment income than they pay in losses and expenses. A simple measure of this is the ratio of paid losses to premiums. Over the last 27 years, and especially over the last 16, the paid loss ratio in medical malpractice coverage has steadily increased. Also, the investment gains of medical malpractice companies have not declined. While the amount of gain medical malpractice companies receive from equities (stocks) has declined, the bond rally caused by the decline in interest rates and realized in the form of capital gains has more than offset this decline. Data from the National Association of Insurance Commissioners shows that expenses including losses have grown faster than premiums while investment gains have remained relatively constant.

Medical malpractice rates are regulated by the states, and state regulators are required by law to turn down rates that are excessive, inadequate or unfairly discriminatory. Insurance companies are also prohibited by law from attempting to recoup prior losses through future rate increases. The fact remains that insurers are fleeing the medical malpractice market, and that if insurers could make money, companies would be coming to the market rather than fleeing it. In a February 7, 2003, letter responding to questions from Senator Gregg, the President of the National Association of Insurance Commissioners stated the following: "To date, insurance regulators have not seen evidence that suggests medical malpractice insurers have engaged or are engaging in price fixing, bid rigging, or market allocation. The preliminary evidence points to rising loss costs and defense costs associated with litigation as the principal drivers of medical malpractice prices." He further stated that "states have strong laws that prohibit price-fixing and anti-competitive practices by insurers."

The true cause of skyrocketing medical professional liability premiums is escalating jury verdicts. According to exhaustive research by the firm Tillinghast-Towers Perrin, "Since 1975 (the first year in this study for which medical malpractice costs are separately identified), the increase in medical malpractice costs has outpaced increases in overall U.S. tort costs. Medical malpractice costs have risen an average of 11.6% per year, in contrast to an average annual increase of 9.4% per year in overall tort costs."[16]

**8. Does the Public Support H.R. 5?**

The results of a January, 2003, Gallup poll show the American public strongly supports the HEALTH Act. The survey of 1,006 adults conducted 1/20-22/03 (margin of error +/- 3%), and released 2/4/03, included the following

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[14] *See* Harris Interactive, "Common Good Fear of Litigation Study: The Impact of Medicine," Final Report (April 11, 2002) ("Executive Summary") at 30 (Table 17), available at www.ourcommongood.com/news.html.

[15] Physician Insurers Association of America (301-947-9000).

[16] Tillinghast-Towers Perrin, U.S. Tort Costd: 2002 Update – Trends and Findings on the U.S. Tort System, at 2.

questions and response percentages:

- Would You Favor Or Oppose The Following Proposals?
  - A limit on the amount patients can be awarded for their emotional pain and suffering? Favor (72%); Oppose (25%).
  - A limit on the amount patients can be awarded as punishment to doctors for negligence or carelessness? Favor (64%); Oppose (31%).

**9. How Do Jesica Santillan and Leanne Dyess Relate to the H.R. 5 Debate?**

- Regardless of the merits of any given case, there are inherent problems with so-called "pain and suffering" or "noneconomic" damages: they are utterly standardless, unquantifiable, and subject to discriminatory application based of whether or not a particular person happens to be sympathetic or unsympathetic, and even whether or not a particular case has attracted media attention. Tony Dyess's injury did not receive media attention. He was in a car accident in Mississippi. There were no longer any neurosurgeons in the area. They had stopped practicing because they couldn't afford medical professional liability insurance. It took six hours to airlift Tony Dyess to a hospital that could treat his brain injury. It was too late. The "golden hour" had passed, and Tony Dyess has been left permanently brain damaged. As Tony Dyess' wife Leanne has said, "From my perspective ... this problem far exceeds any other challenge facing America's health care -- even the challenge of the uninsured. My family had insurance when Tony was injured. We had good insurance. What we didn't have was a doctor. And now, no amount of money can relieve our pain and suffering. But knowing that others may not have to go through what we've gone through, could go a long way toward helping us heal."

- Despite the prospects of lawsuits, Jesica Santillan's surgeon, Dr. James Jaggers, has publicly accepted blame for the erroneous organ transplant. He is a top surgeon, and one who spends his holidays performing heart surgery, free of charge, for children in Nicaragua. He has disclaimed any responsibility by the hospital, saying in a public statement, "I am ultimately responsible for the team and for this error."[17] Jesica Santillan was smuggled into the United States because Americans are blessed with the finest surgeons in the world. But even the finest surgeons are human. The rest of us are human, too. We make mistakes. We get injured. We get sick. And we need our doctors to keep practicing and to keep healing, human as they are.

- We don't know all the facts surrounding Jesica Santillan's situation. However, we do know that unlimited lawsuits do not prevent medical mistakes from occurring. In fact, North Carolina is one state with no medical liability reforms on the books – including no limits on "pain and suffering" damages, no limits on trial lawyer contingency fees, no limits on double recoveries, and no joint and several liability reforms – but unlimited liability did not act as a deterrent to error in this situation. At the same time, real patients are being denied access to care and losing their family doctors because of exorbitant medical liability costs.

- Under H.R. 5, there are no limits placed on any quantifiable damages that can be awarded against responsible parties. As the experience of California has shown, such awards for quantifiable damages in the case of children have been in the many tens of millions of dollars. In just the last few months, for example, an injured child in California received an award of $84 million in quantifiable economic damages. The amount of quantifiable damages that may be awarded for the death of a child varies by state law, but under state survival statutes parents

[17] Sarah Avery, "Jesica Dies of Brain Damage," *Raleigh News & Observer* (February 23, 2003) at A1.

can sue for economic losses resulting from a child's death. In "full earnings states," the estate can bring an action for recovery of the entire amount of the decedent's expected lost earnings or lost earning capacity. In "personal maintenance states," the estate can bring an action for recovery of the decedent's lost earnings net of personal maintenance expenditures. Under the HEALTH Act, states remain free to define how quantifiable economic losses are calculated in cases such as Jesica Santillan's. In those very rare cases in which a plaintiff was injured yet can demonstrate absolutely no quantifiable economic losses under state law, that plaintiff can still get up to $250,000 in noneconomic damages and up to $250,000 in punitive damages under H.R. 5, for a total of $500,000 (half a million dollars) in damages when under state law absolutely no quantifiable damages at all result from an alleged injury -- and even then H.R. 5 saves from preemption any state law that limits noneconomic damages, or any other damages, at a specific amount higher than the limits provided for in H.R. 5. That means that if a state law limited noneconomic damages to $1 billion, that state law would govern, even under H.R. 5.

10. **What's the Big Picture?**

- We all recognize that injured victims should be adequately compensated for their injuries. But too often in this debate we lose sight of the larger health care picture. The best evidence about medical injuries comes from two large studies of hospital records, which both concluded that under one percent of hospital charts showed negligent medical injury.[18] This country is blessed with the finest health care technology in the world. It is blessed with the finest doctors in the world. People are smuggled into this country for a chance at life and healing – the best chance they have in the world. Just read the report charting health trends recently issued by the Department of Health and Human Services.[19] During the past half century, death rates among children and adults up to age 24 were cut in half. Mortality among adults 25-64 years fell nearly as much, and dropped among those 65 years and over by a third. The infant mortality rate has plummeted 75% since 1950. These amazing statistics didn't just happen. They happened because America produces the best health care technology and the best doctors to use it. But today, there are fewer and fewer doctors to use that miraculous technology, or to use that technology where their patients are.

- For example, we have the best brain scanning and brain operation devices in history, and fewer and fewer neurosurgeons to use them. According to the American Board of Neurological Surgery, in 2001 alone, 327 board-certified neurosurgeons retired, an alarming 10% of the entire neurological workforce in the United States. Only about 150 neurosurgeons graduate from residency training programs each year, and it takes about 5 years of post-residency to become board certified. Yet while fewer and fewer neurosurgeons can be reached by injured people within the "golden hour" that often separates life and death, the number of lawyers in this country is increasing much faster than the population. Unlimited lawsuits – driven by lawyers' lust for their cut of unlimited awards for unquantifiable damages – are driving doctors out of the healing profession. They're setting back the clock. They're making us all less safe. When someone gets sick, or is bringing a child into the world, and we can't call a doctor, who will we call? A lawyer?

- As amazing as America's health statistics are, here's one more thing to keep in mind. California -- where the

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[18] D. Mills, J. Boyden, and D. Rubsamen, "Report on the Medical Insurance Feasibility Study," (San Francisco: Sutter Publications 1977, sponsored jointly by the California Medical Association and California Hospital Association); A. Localio, A. Lawthers, T. Brennan, N. Laird, L. Hebert, L. Peterson, J. Newhouse, P. Weiler, and H. Hiatt, "Relation Between Malpractice Claims and Adverse Events Due to Negligence," New Engl. J. Med. 325:245-251 (1991).

[19] Available at http://www.cdc.gov/nchs/releases/02news/hus02.htm.

reforms in H.R. 5, including its cap on noneconomic damages, have been the law for over 25 years -- has even healthier people than the nation as a whole. According to California Health Statistics for the year 2000 (the most recent available information) the overall mortality rate in California is 24% below the national average and the infant mortality rate in California is 19% below the national average. Lower noneconomic damage awards in California have led to healthier people.

- Under H.R. 5, victims will be fairly compensated and medical errors will be deterred. Without H.R. 5, victims will be left to suffer and die because there will fewer doctors there to treat them. Sound policy does not favor supporting people's abstract ability to sue a doctor for unlimited, unquantifiable damages when doing so means that there is no doctor to treat people in the first place. The American Bar Association estimates there are 1 million lawyers in America. But all of us – all 287 million Americans – are patients. As patients, and for patients, Congress should pass H.R. 5.

For Immediate Release
Office of the Press Secretary
January 16, 2003

## President Calls for Medical Liability Reform

Remarks by the President on Medical Liability Reform
University of Scranton
Scranton, Pennsylvania

Multimedia
President's Remarks
view
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- Fact Sheet
- Policy in Focus: Medical Liability

THE PRESIDENT: Thank you all. Please be seated. Thanks for coming, and thanks for the warm welcome -- inside. (Laughter.) It's great to be back in Scranton, Pennsylvania. (Applause.) Home of a lot of really fine people and a great university.

And I want to thank the University of Scranton -- (applause.) I want to thank the University of Scranton for the hospitality. I want to thank Father Joe McShane for opening up this wonderful facility for me, and a lot of members of the congressional delegation have come, and the great Secretary of Health and Human Services, Tommy Thompson. (Applause.)

I appreciate you all putting up with us, and giving me a chance to talk about a significant problem which faces America. And that problem is the fact that our medical liability system is broken, and therefore, a lot of Americans don't have access to affordable health care. And I'm here to declare in Pennsylvania I intend to work with Congress to do something about it and fix the problem. (Applause.)

And we're going to need your help. Democracy can respond. People in Washington tend to respond when the people speak. (Laughter.) So I'm going to spend a little time today encouraging you and those who may be watching on TV to start speaking on your behalf, to make sure that you can afford health care in America. (Applause.)

I'm traveling today with some mighty fine folks. One person decided to go back to Washington to represent Pennsylvania's interest on the Senate floor. He flew up with me. I talked to him about this issue, and that's Senator Arlen Specter. I want to thank him for his friendship. (Applause.) It looks like they're finally getting organized in the United States Senate. (Applause.) And they might start voting on the appropriations bill for '03, which would be helpful. (Laughter.)

I also was traveling with Jim Greenwood. I'm honored that Jim was on the plane. Jim was a sponsor in the House of Representatives of the legislation which I'm going to talk to you about today and which I hope I'm able to sign into law this year, to help the doctors and patients in the state of Pennsylvania. I appreciate you. (Applause.)

Paul Kanjorski is here, as well, the member of the United States House of Representatives. Paul, I'm honored you are here. The issue we're talking today about is not a Republican issue, it's not a Democrat issue; it's an issue which affects people from all walks of life. And it's an issue which must be solved. (Applause.)

A man who used to represent Scranton is Don Sherwood. I appreciate Don and his friendship. Thank you for coming. (Applause.) With us, as well, is two other fine members of the congressional delegation from Pennsylvania, Todd Platts and Pat Toomey, and I want to thank you guys for being here today. (Applause.)

I'm honored that the Mayor of Scranton, Chris Doherty, is here with us. Mr. Mayor, thank you. (Applause.) He was standing out there in the cold, waiting for Air Force One. That's beyond the call of duty, I want you to know.

(Laughter.) But thank you, sir. I appreciate so very much the Attorney General of the State of Pennsylvania, my friend, Mike Fisher. I'm glad you're here, Mike. (Applause.) John Perzel is here, from -- representing the House of Delegates, along with the senators and members of the House from this part of Pennsylvania. I'm honored you guys are here. Thank you for coming. Thank you for your interest in this issue. (Applause.)

Today when I arrived, I met Ed Gilmartin. He's what we call a USA Freedom Corps greeter. He is a volunteer with the Goodwill Industries of Northeastern Pennsylvania. I want to thank Ed for coming. I want to thank him for working with Goodwill. He is a reminder that while one of us can't do everything to help heal the hurt of America, each of us can do something to help make somebody's life in your community a better place. (Applause.) And that, as we continue our struggle against people who are evil who would want to hurt America, that we can do so not only through the use of our great military, but we can do so by doing some good in our communities, in order to fight evil. Each of us can do some good by loving a neighbor just like you'd like to be loved yourself.

See, we've got some big problems in this country. I'm here to talk about one problem, but we've got some others. One is, how best to secure the peace. And one way to secure the peace is never to forget what happened to us on September the 11th, and hunt the killers down one by one and bring them to justice, which is what America is going to do. (Applause.)

We will continue to confront problems before they become acute. We understand that the world was changed on September the 11th. Oceans no longer protect us from threats that may mass overseas. And that's why I've been clear about my desire to keep the peace by confronting Mr. Saddam Hussein. It's his choice to make. It's up to Mr. Saddam Hussein to do what the entire world has asked him to do. The world overwhelmingly, through the U.N. Security Council, said, Mr. Saddam Hussein, disarm for the name of peace. It's his choice to make. So far, the evidence hasn't been very good that he is disarming. And time is running out. At some point in time, the United States' patience will run out. In the name of peace, if he does not disarm, I will lead a coalition of the willing to disarm Saddam Hussein. (Applause.)

We will deal with those problems overseas, and we will deal with the problems we have at home, as well. We've got an economy that is not as strong as it should be. And therefore, I've proposed to Congress ways to strengthen the economy, starting with this principle: It is best to let Americans have more of their own money, if you're worried about economic vitality. (Applause.)

If you want people to find work, if you're worried about somebody looking for a job, like I am, the best way to encourage economic growth is to let people have more of their own money. And one of the lessons that I keep trying to explain to Washington and, of course, these members don't need to hear it is that the money we spend in Washington is not the government's money; it's the people's money. (Applause.)

I look forward to working with Congress. I look forward to working with Congress to create an environment in which the small businesses grow to be big businesses, in which the entrepreneurial spirit is strong, and, most importantly, in which people who are looking for a job can find work. (Applause.)

But the problem I want to talk today is the problem with our health care system. I hope you're as proud of our health care system as I am. I mean, we're great at what we do. (Applause.) We've got great doctors in America. (Applause.) Incredibly skilled, well-trained, compassionate people who care deeply for their patients. We've got great nurses in America. (Applause.) People who love their patients. We've got fine hospitals, fine researchers. We're on the leading edge of technological change in this country. We make new discoveries all the time. We develop new cures and, therefore, we develop new hopes for people who are sick. We're good at what we do. And I'm proud of the health care system of America. (Applause.)

But we've got some problems. And one of my jobs is to talk plainly about the problems, and encourage people to find solutions to the problems and then get them to act. We've got a problem because too many of our citizens go without health care. That's why I proposed refundable tax credits to empower people to be able to have the capacity to get into the marketplace to purchase health care.

We've got a lot of people who go to emergency rooms for primary care, which strains our emergency rooms. It makes it hard on the community hospitals. That's why I'm for community health centers, realistic, smart ways to make sure people can get primary health care who don't have it.

Our seniors need to have a reformed Medicare plan which includes prescription drugs. (Applause.) We've got a system that's stuck in the past. Medicare is stuck. Medicine has become modern, and Medicare hadn't. And it seems like to me a good place for Congress to start is to take a look at their own health care system. They've got choice in the system. Congressmen and senators and their staffs can pick and choose the plan that meets them best. It seems to me a good principle for our seniors, to trust our seniors to make the right decisions for them. (Applause.)

And medical care is expensive. Out of $100 spent in this country, $11 goes to pay for health care. The costs are rising at the fastest rate in nearly a decade. I mean, that's a problem. Most costs in our economy are pretty well under control; inflation is low. But that's not the case in health care. And we need to do something about it, before people get hurt.

Health care costs rise for a lot of reasons. Research is costly. Technologies cost money, and they're expensive. And some of the costs are necessary. But there are some costs that are unnecessary as far as I'm concerned. And the problem of those unnecessary costs don't start in the waiting room, or the operating room, they're in the courtroom. (Applause.) We're a litigious society; everybody is suing, it seems like. There are too many lawsuits in America, and there are too many lawsuits filed against doctors and hospitals without merit. (Applause.)

And one thing the American people must understand is, even though the lawsuits are junk lawsuits and they have no basis, they're still expensive. They're expensive to fight. It costs money to fight off a junk lawsuit. And oftentimes, in order to avoid litigation, and oftentimes, to cut their costs, docs and, therefore, the companies that insure them just settle. See, so even though there's no merit, in order just to get rid of the thing, they just say, okay, let's just pay you. We'll get you out of the way. Instead of maybe suffering the consequences of a lousy jury and a lousy verdict, just pay them off. That is expensive to the system when it happens time and time and time again, like it's happening in America today. (Applause.)

And what's happening is these rates for insurance are going out of sight. And doctors need insurance to practice. Today I met with a lot of great health-givers and healers, decent people, compassionate Americans who love their patients. These are docs -- I met with some patients, as well -- talking about the effects of this litigious society we have. And I heard stories about people not being able to pay their premiums. See, that means that health care is no longer accessible to too many of our citizens. When a doc can't pay the premiums and, therefore, can't practice, somebody is going without health care. It's strains the system.

So what happens is, doctors say, well, gosh, I can't afford it here in Pennsylvania, I'm moving. I'll just take my heart and my skills to another community where I can afford it. But when that happens, somebody hurts. Somebody doesn't have the care. Some mom fixing to have a baby wonders out loud -- when she wonders out loud whether or not the doc is going to be there to deliver the baby, it's a -- we heard a story, by the way, about that -- it's a sad situation. There's a lot of uncertainty in our society. Lawsuits run up the costs for you, the patient. But they also create a sense of uncertainty in America for people who need the stability of good care.

I had a chance to, when I talked to the docs, to talk about people who literally had tears in their eyes when they described their situation. Debra DeAngelo and her husband are leaving Scranton to go to Hershey. They wanted to stay here in Scranton, they were raised in Scranton. I met one of Debra's patients who really needs her to be in Scranton. They chose so because they can get their insurance there and they can't here.

This insurance issue is creating a problem in our communities all across America. People are having to move. People who don't want to move have to move in order to stay in business to be able to do their job.

Jack Brooks is a respected pathologist at the University of Pennsylvania Hospital. He was there today. He went to Buffalo. He moved back to his state, but he was turned down by three insurers when he came back to Pennsylvania. The fourth insurer's quote was just too high, he couldn't afford it. Jack Brooks has never had a claim filed against him. He's one of your leading docs here in the state of Pennsylvania. He's one of your best assets. He's never been to the courthouse. And yet, because the system is broken, he couldn't afford to be in Pennsylvania. Fortunately, he got some insurance through a hospital; he couldn't do it on his own. You've got a problem here in this state. (Applause.)

Greg Przybylski was here. He's a brain doctor. He has been moving from Pennsylvania to Illinois to New Jersey

because the costs were too high. He can't stay in business. He can't do what he was trained to do and loves to do, which is to treat patients. He talked about when he was living in Chicago, he talked about a patient of his who had incredible complications. The guy couldn't find help in Pennsylvania, so the man drove all the way out to Chicago to be treated by Greg. That says a lot about Greg. It says a lot about his patients. And unfortunately it says something bad about the health care system, when liability costs are such that you can't get the kind of care that you need in Pennsylvania.

You're not alone, though. It's not just your state that's got a problem. We heard from an OB/GYN in the state of Florida about how she couldn't get insured. And in Nevada, pregnant women sometimes have to leave the state to find a doctor. One woman called more than 50 local doctors and couldn't find one to serve her. So she's going to go to Utah to have her baby.

I was down in Mississippi recently to talk about this issue. There's a doc and his wife who's also a doctor, who came from up north down to Mississippi in the Delta region of that state. And the Delta region has got a lot of people who hurt, a lot of people who are needy, a lot of people who need health care. And they went, not to build a giant portfolio of wealth; they went because they got great hearts. They heard a calling. They heard he would have attributed it to the Almighty. Having watched him, I would have attributed it to the Almighty, too. He has got a fantastic heart to him. I could see that he was inspired. He told me he's leaving the Delta because the trial lawyers ran him out. He couldn't practice medicine without getting sued.

Something's wrong with the system. And a broken system like that, first and foremost, hurts the patients and the people of America. (Applause.)

Twenty percent of hospitals nationwide have had to cut down on certain services -- on delivering babies, or neurosurgery, or cardiovascular surgery, or orthopedic surgery. That's a fact. So the problem is not only for Pennsylvania, it's a problem for our country.

And there's another cost driver. And if you're worried about getting sued all the time, then there is the natural tendency to practice what they call defensive medicine. In other words, you order tests that someone may not need, to protect yourself in a court of law. And that's costly, and that's one of the main reasons why costs are going up. These lawsuits have got a lot of effects on our country, and we've just got to understand that.

This is an incredibly important issue for states. I obviously hope the state of Pennsylvania is able to address it. That can happen in the statehouse. When I got to Washington, I said, that's an important issue for the states. And then it didn't take me long to realize, this is an important issue for the federal government, too, and I'll tell you why. (Applause.) The direct cost of malpractice insurance and the indirect cost from defensive medicine raise the federal government's health care cost by at least $28 billion a year. Malpractice, defensive practice of medicine affects Medicare, Medicaid, veterans' health, government employee costs. It affects the federal government. Therefore, it is a federal issue. (Applause.)

It is a national problem that needs a national solution. (Applause.) And here it is -- first, let me just say this as clearly as I can -- we want our judicial system to work. People who have got a claim, a legitimate claim, must have a hearing in our courts. Somebody who has suffered at the hand of a lousy doc must be protected. And they deserve a court that is uncluttered by frivolous and junk lawsuits. If they prove damages, they should be able to recover the cost of their care and recovery and lost wages and economic losses for the rest of their life. That's fair. That is reasonable. And that is necessary for us to have confidence in the medical system and in the judicial system. (Applause.)

Yet, for the sake of affordable and accessible health care in America, we must have a limit on what they call non-economic damages. (Applause.) And I propose a cap of $250,000. (Applause.) Otherwise, if not, excessive jury awards, like those in Pennsylvania, and those I was just -- one was just described to me -- today a guy held up a full-page ad in your newspaper paid for by the excessive jury award. (Laughter and applause.) Excessive jury awards will continue to drive up insurance costs, will put good doctors out of business or run them out of your community, and will hurt communities like Scranton, Pennsylvania. That's a fact. (Applause.) And that's why we need a cap on non-economic damages, and that's why we need a cap on punitive damages, as well. (Applause.)

As I mentioned to you -- and it's important for our citizens to understand -- it is the fear of unlimited non-

economic damages and punitive damages that cause docs and the insurance carriers to unnecessarily settle these cases. See, you can pretty well blackmail a doctor into settlement if you continue to throw lawsuit after lawsuit, and the system looks like a giant lottery. (Applause.) Thank you.

There needs to be other reforms, as well. A lot of times, these lawyers will sue everybody in sight in order to try to get something. In cases where more than one person is responsible for a patient's injuries, we need to assign blame fairly. We need joint and several liability reform in our medical liability system. (Applause.)

We need to make sure that doctors can take care of their patients without fear that their advice will be used against them some day. It's hard to believe a system (applause). You hear a lot about the doctor-patient relationship -- it's an incredibly important relationship, in order to make sure we have a health care system that functions well. And yet imagine a system where docs can't share information amongst each other, much less talk to your patient, for fear that what they say will be used them -- in court one day.

The system is not balanced, if that's the case. The system is not fair. The system doesn't need to have a relationship with the doc and the patient for fear of what is said will be used by a lawyer to sue them. That's why we need these reforms, for the good of the country.

We got the bill passed out of the House, thanks to Jim and the members of the delegation here. And I want to thank you for your leadership and your vote. (Applause.) And the Senate didn't act on it, so we've got to start over. And I'm ready to start over. (Applause.) And the time is getting worse. That's what people have got to understand up there in Washington or over there in Washington down there in Washington, whatever. (Laughter.) Thought I was in Crawford for a minute. (Laughter and applause.)

And this is I repeat, this is a national problem and we just cannot allow a bunch of needless partisanship to prevent a good, solid solution from going forward. (Applause.) And let me say one other thing. This problem won't be solved by just throwing money at the problem. This problem will be solved by getting at the source of the problem, which are the frivolous lawsuits. (Applause.)

If you're looking for solutions in Pennsylvania, look at states which have done a good job of helping the patient out. California is one example. More than 25 years ago, they passed a law that caps damages from malpractice suits. And the law has worked.

Let me tell you a startling statistic. Reports from Philadelphia say that juries there have awarded more in malpractice damages than the entire state of California did over the last three years. That says two things. California's law is what people in your statehouse ought to look at, and you've got a problem in Pennsylvania. (Applause.) There was a good news story in Mississippi. I went down there and -- it wasn't because of me, it was because the doctors and the citizens understand the cost of a trial system gone array and they got themselves a law. And they got a medical liability law. They put caps, real caps. Guess what happened? In some counties, the malpractice claims rose dramatically before the law came into effect. (Laughter.) Now, what does that tell you about the system? It tells you the system is less about justice and more about something that looks like the lottery, is what it looks like to me. (Applause.) And with the plaintiffs bar getting as much as 40 percent of any verdict, sometimes there's only one winner in the lottery. (Applause.)

We need reform. You need reform in Pennsylvania, and we need reform all across America, and we need a law coming out of the United States Congress. (Applause.) It's a law that recognizes the centerpiece of good health care is to worry about your patient, the American people. It's a law that will recognize that an affordable and accessible health care system can best be had if we limit the caps -- put caps on non-economic and punitive damages. That's what I understands. (Applause.)

Congress needs to act on this law. Congress needs to listen to the people and not make excuses as to why they can't get something done. I believe we'll get something out of the House. I believe we'll get us a good law out of the House. And then the Senate must not fail its responsibilities to the American people again. (Applause.)

And you can help. Every state's got them a couple of senators. (Laughter.) And they need to hear from you. I consider your two senators allies, but they need to hear from you. Every state, people who are concerned in every state about whether or not they're going to have affordable health care, or health care at all, need to

contact the people that represent them. See, democracy can work. Democracy makes a difference. When the people speak, the folks in Washington, D.C. listen. (Applause.) And I'm here to ask you to join in this important cause, for the sake of people you care about -- your loved ones and your neighbors and the people in your communities.

No, we've got a lot of problems facing America. We've got the responsibility to make the world more peaceful. We have the responsibility to make sure our homeland is secure. We've got the responsibility to make sure every child is educated. We have a responsibility to make sure our health care systems work. We've got a lot of problems. But I'm going to tell you something about this country. In my mind, there is no doubt that we won't solve these problems, because this is the greatest nation, full of the finest people, on the face of the Earth.

Thank you for coming. May God bless. Thank you all.

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# Commentary

**BRUCE BARTLETT**

## Toll of torrential torts

In recent days, there have been numerous press stories about doctors going on strike to protest high medical malpractice premiums. This is just the most obvious evidence that something is fundamentally wrong with the nation's tort liability system. A number of reports suggest the cost is growing out of control, imposing a de facto tax on all Americans that is slowing economic growth and investment, while doing little for those suffering real harm.

According to a new study by Tillinghast-Towers Perrin, the total cost of the U.S. tort system reached $205.4 billion in 2001, an increase of 14.3 percent over the previous year — far faster than the rate of economic growth. This is like a tax of 2 percent on everything in the American economy that takes $721 per year out of the pockets of every citizen. This cost is paid in the form of bankrupt companies, reduced investment and jobs, higher prices for medical insurance and many other goods and services.

Of course, any civilized society has to have a means of compensating victims of personal injuries resulting from medical mistakes, harmful products and such. But the cost of compensating people for these problems has been going up rapidly without any evidence that the underlying causes are increasing. Doctors are not making more mistakes than they used to and businesses are not manufacturing more dangerous products than they used to. Yet the cost of torts has risen from just more than 1 percent of the gross domestic product in 1973 to twice that this year.

Responsibility for rising tort costs lies mainly with greedy trial lawyers who sue based on the flimsiest of evidence, and out of control juries that think nothing of awarding hundreds of millions of dollars in damages at the drop of a hat. Last year, for example, a jury in California awarded $290 million to the family of three people killed in the rollover of a Ford Bronco. Many other examples can be found at www.overlawyered.com, an excellent Web site that, unfortunately, I find too depressing to read regularly. According to Jury Verdict Research, the median medical malpractice award doubled between 1995 and 2000, from $500,000 to $1 million.

In recent years, a key cause of rising tort costs has been asbestos. As trial lawyers search farther and farther for "deep pockets," more than 6,000 companies have become embroiled in litigation, according to a recent Rand study. These defendants include many companies far outside the asbestos and building products industries. They have already paid out $54 billion, yet it is estimated there are still another $200 billion to $265 billion in claims yet to be paid.

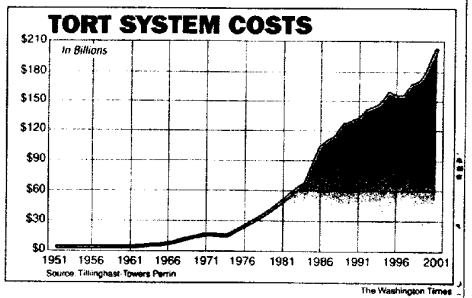
Increasingly, the only way companies can cope with rising asbestos liabilities is by declaring bankruptcy. Some 80 companies have already done so. These bankruptcies have cost at least 60,000 jobs, according to a new study by economists Joseph Stiglitz, Jonathan Orszag and Peter Orszag. Each worker lost $25,000 to $50,000 in wages as the result of these asbestos-related job losses, plus another $8,300 in losses in their 401(k) plans.

The rise in asbestos awards has less to do with an increase in asbestos-related illnesses than the failure of a few judges to do their jobs properly. According to a study by economist Michelle White, a few judges in a few jurisdictions are responsible for the bulk of asbestos awards. Perhaps inadvertently, they have changed the rules of the game for defendants, increasing the likelihood that plaintiffs will get large awards and encouraging lawyers to file as many cases as possible.

Yet despite the massive increase in awards, little reaches those that really need it. Rand found that transactions costs eat up 50 percent of all the money and 65 percent of what reaches plaintiffs goes to those who have not yet — and may never — develop any asbestos-related disease. Looking at all tort cases, Tillinghast-Towers Perrin found that only 22 percent of tort costs compensated victims for actual losses.

What is frightening is that the link between medical malpractice or corporate malfeasance and any scientific evidence of wrongdoing or error is becoming increasingly tenuous. For example, a new report by the American College of Obstetricians and Gynecologists found that cerebral palsy almost never results from problems in childbirth. Yet victims of this condition are routinely awarded large sums as if the delivery doctor was solely at fault. Similarly, billions of dollars were awarded to women with silicon breast implants even though there is no scientific evidence that they cause illness, according to the Institute for Medicine.

Judges and juries must learn that the money they are awarding is not free money from the tooth fairy. The tort system today is severely broken and in desperate need of reform. Even the American Bar Association, whose members are enriched by it, has come to agree.




*Bruce Bartlett is senior fellow with the National Center for Policy Analysis and a nationally syndicated columnist.*

OPED The Washington Times • MONDAY, MARCH 3, 2003 / PAGE A19

# Malpractice remedies

## Voters know system ails from litigation costs

**By Gary J. Andres and Michael McKenna**

Just when you thought the trial bar had infected malpractice reform with a resistant strain of obstructionism, the immune system of the body politic is poised to strike back. The results of the recent American Survey (conducted in early February among 600 voters; margin of error plus/minus 4.0 percent) suggest that the debate over medical malpractice is no longer viewed as a tournament of greed, pitting rich doctors against even wealthier trial attorneys. As long as the struggle was confined to that small group of combatants, the status quo prevailed. But the contagion has spread, spilling into America's living rooms on the nightly news with stories about doctors going on strike and hospital emergency rooms where patients receive delayed or deferred care.

In fact, voters seem to understand that unrestrained litigation raises health-care costs, jeopardizes access, and — most ominously for those who hope to ward off reform efforts — seriously impairs the quality of the health care delivered. More specifically, a majority of voters — six in 10 — made the crucial connection and concluded that costs associated with medical malpractice were affecting their health-care costs. Even more surprising was that most draw a strong linkage between medical malpractice costs and health-care quality; almost three-quarters of the respondents were very or somewhat concerned about the deterioration in the quality of health care due to rising medical malpractice costs.

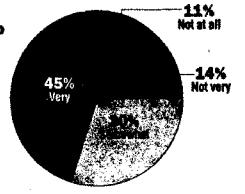
In short, it appears that a sizable portion of voters fully grasp the impact of a broken malpractice system and want it fixed. This emergent salience should send policymakers a clear signal that the time and environment is ripe for reforms — including placing caps on non-economic damages — like those proposed by President Bush and some in Congress.

Those sorts of reforms seem to more closely track voters' thoughts. For example, while people blame trial lawyers for a sizable amount of the problem (when offered several choices, 45 percent of respondents noted that trial lawyers were to blame when doctors were forced to strike or quit), respondents thought that capping jury awards (36 percent) was a better fix than reining in trial lawyers (12 percent). This suggests that while trial lawyers are in a bad spot on this issue, people are still (!) reluctant to put them, as a group, on a leash.

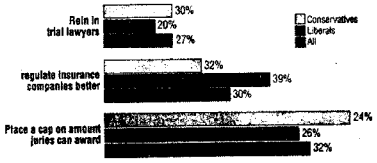
Nevertheless, this strong voter concern about how malpractice policies affect whether they can see a doctor, the quality of the care and how much they pay is a lethal combination of attitudes that should embolden reform advocates.

*Gary J. Andres is a senior managing partner with the Dutko Group and a former White House senior lobbyist. Michael McKenna is co-founder of Andres-McKenna Research and a vice president at the DutkoGroup. E-mail: Mike.Mckenna@arm-polling.com.*

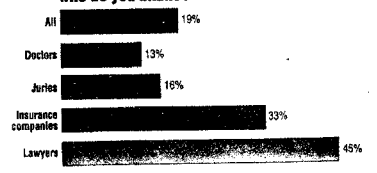
**How concerned are you about losing access to your doctor or experiencing problems in the quality of your health care because of increasing medical malpractice costs?**




**How do you think this problem should be solved?**




**When doctors strike or quit, who do you blame?**



PREMIER

February 26, 2003

The Honorable Jim Greenwood
United States House of Representatives
2436 Rayburn House Office Building
Washington, D.C. 20515

Dear Rep. Greenwood:

On behalf of the nearly 1,600 leading not-for-profit hospitals and health systems allied in Premier, we extend our vigorous support for the "Help Efficient, Accessible, Low Cost, Timely Health (HEALTH) Act of 2003" (HR. 5). We are confident that the bold initiatives outlined in this bipartisan legislation would be of immense benefit to the millions of Americans struggling to secure access to critical healthcare services.

HR. 5 attempts to address the unsustainable rise in medical liability insurance rates in numerous states. As you know, circumstances such as these have compelled—and, unremedied, will continue to compel—physicians and other practitioners to relocate or reduce their practices, or to suspend their care services altogether. Skyrocketing liability insurance rates have proven particularly troublesome for hospitals, which are already working to mitigate the effects of key healthcare personnel shortages at a time when the demand for increasingly complex medical services is on the rise.

This legislation would make positive changes to medical liability law without compromising the ability of injured patients to receive full payment for economic losses. HR. 5 would reasonably limit non-economic damages, provide joint and several liability ('fair share rule'), allow periodic payment of future damages, and institute commonsense award reforms to safeguard community access to quality care.

Again, we are grateful for your leadership on this issue, and look forward to working with you toward enactment this year.

Sincerely,

Herb Kuhn
Corporate Vice President
Premier Advocacy

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